

Substance Abuse Among Older Adults: A Guide for Treatment Providers

Based on Treatment Improvement Protocol (TIP) 26



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Substance Abuse Among Older Adults: A Guide for Treatment Providers

Treatment Improvement Protocol (TIP) Series

26

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Foreword

CSAT Concise Desk Reference Guides (CDRGs) are companion publications to Treatment Improvement Protocol (TIPs) publications, which reflect best practice guidelines for the treatment of substance abuse. CSAT's Office of Evaluation, Scientific Analysis, and Synthesis draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPs, which are distributed to a growing number of facilities and individuals across the country. CDRGs are condensed versions of TIPs, edited and summarized to provide pertinent substance abuse treatment information targeting professionals in particular fields. Target audiences for the CDRGs include primary care physicians, substance abuse treatment providers, social service providers, administrators of substance abuse treatment programs, and others. The major goal of each CDRG is to convey "front-line" knowledge responsibly and quickly to practitioners in each of these disciplines.

This CDRG is abstracted from TIP 26, *Substance Abuse Among Older Adults*. It presents social service providers with quick, easy access to vital, field-related knowledge. Substance abuse often goes undetected among adults over 60 in part due to societal reasons—older adults tend to be ashamed

about drinking or drug problems and see them as a moral failing. Physicians may confuse symptoms of substance use disorders with age-related changes and disorders such as dementia and delirium. The issues of most concern to caretakers and social providers who work with this population are presented here. This CDRG also addresses legal and ethical issues and provides assessment and evaluation instruments for use with older adults.

TIP 26, *Substance Abuse Among Older Adults*, as well as other TIPs and CDRGs, may be ordered by contacting the National Clearinghouse for Alcohol and Drug Information (NCADI) at (800) 729-6686 or (301) 468-2600; TDD (for hearing impaired), (800) 487-4889.

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Chapter 1

Substance Abuse Among Older Adults: An Invisible Epidemic

Researchers are only beginning to realize the pervasiveness of substance abuse among people age 60 and older. Until relatively recently, alcohol and prescription drug misuse, which affects as many as 17 percent of older adults, was not discussed in either the substance abuse or the gerontological literature.

The reasons for this silence are varied: Health care providers tend to overlook substance abuse and misuse among older people, mistaking the symptoms for those of dementia, depression, or other problems common to older adults. In addition, older adults are more likely to hide their substance abuse and less likely to seek professional help. Many relatives of older individuals with substance use disorders, particularly their adult children, are ashamed of the problem and choose not to address it. The result is thousands of older adults who need treatment and do not receive it.

The Problem Projected

It will be increasingly difficult for older adults' substance abuse to remain a hidden problem as the demographic bulge known as the Baby Boom approaches old age early in the next century

- Census estimates predict that 1994's older adult population of 33 million will more than double to 80 million by 2050 (Spencer, 1989; U.S. Bureau of the Census, 1996).
- Life expectancy in the United States has increased. In 1950, it was 68 years, and by 1991, it had reached 79 years for women and 72 years for men (U.S. Bureau of the Census, 1996).

Not only are adults in general living longer, substance abusers are also living longer than ever before (Gomberg, 1992b). Thus, more Americans face chronic, limiting illnesses or conditions such as arthritis, diabetes, osteoporosis, and senile dementia, becoming dependent on others for help in

performing their activities of daily living (U.S. Bureau of the Census, 1996).

The Problem Now

Alcohol Disorders: Older Adults' Major Substance Abuse Problem

Problems stemming from alcohol consumption, including interactions of alcohol with prescribed and over-the-counter drugs, far outnumber any other substance abuse problem among older adults. Community prevalence rates range from 3 to 25 percent for "heavy alcohol use" and from 2.2 to 9.6 percent for "alcohol abuse" depending on the population sampled (Liberto et al., 1992). Chapter 2 recommends a drinking maximum for older adults. A recent study found that 15 percent of men and 12 percent of women age 60 and over treated in primary care clinics regularly drank in excess of limits recommended by the National Institute on Alcohol Abuse and Alcoholism (i.e., no more than one drink per day) (Saunders, 1994; Adams et al., 1996; National Institute on Alcohol Abuse and Alcoholism, 1995).

Prescription Drugs

Older patients are prescribed benzodiazepines more than any other age group, and North American studies demonstrate that 17 to 23 percent of drugs prescribed to older adults are benzodiazepines (D'Archangelo, 1993). The dangers associated with these prescription drugs include problematic effects due to age-related changes in drug metabolism, interactions among prescriptions, and interactions with alcohol.

Unfortunately, these agents, especially those with longer half-lives, often result in unwanted side effects that influence functional capacity and cognition, which place the older person at greater risk for falling and for institutionalization (Roy and Griffin, 1990). Attention, memory, physiological

arousal, and psychomotor abilities are often impaired as well (Pomara et al., 1985), and drug-related delirium or dementia may wrongly be labeled Alzheimer's disease. Misuse of psychoactive prescription drugs is discussed in Chapter 3.

Older Adults' Unique Vulnerabilities

Because many of the definitions, models, and classifications of alcohol consumption levels are static and do not account for age-related physiological and social changes, they simply do not apply to older adults.

Further complicating treatment of older substance abusers is the fact that they are more likely to have undiagnosed psychiatric and medical comorbidities. According to one study, 30 percent of older alcohol abusers have a primary mood disorder (Koenig and Blazer, 1996). A thorough evaluation of all problems is essential when caring for older adults: Failure to do so will undoubtedly increase the number of false diagnoses and diminish the quality of older patients' lives (Gomberg, 1992a).

Barriers to Identifying and Treating Older Adults With Substance Abuse Problems

The sheer number and the interconnectedness of older adults' physical and mental health problems make diagnosis and treatment of their substance abuse more complex than for other populations. That complexity contributes—directly or indirectly—to the following barriers to effective treatment:

Ageism

The term *ageism* was coined in the mid-1960s (Butler, 1969) to describe the tendency of society to assign negative stereotypes to older adults and to explain away their problems as a function of being old rather than looking for specific medical, social, or psychological causes.

Lack of Awareness

A second barrier to treatment is a lack of awareness on the part of the older substance abuser, his or her loved ones, the community, and society as a whole. A lack of awareness or denial of the signs of

alcohol abuse (more common among older adults), combined with the personal or community-specific stigma of the disease, may effectively raise one or more barriers to treatment.

Clinicians' and Service Professionals' Behavior

Health care and older adult service providers may be as slow to spot a substance abuse problem as everyone else is: Despite its frequency, there is often a low index of suspicion for this problem. Even when there is the suspicion of a substance abuse disorder, the service provider may have difficulty applying the diagnostic criteria to a wide variety of nonspecific symptoms. With an older patient, health care providers are often in a quandary—symptoms such as fatigue, irritability, insomnia, chronic pain, or impotence may be produced or influenced by substance abuse, common medical and mental disorders, or a combination of these conditions.

Comorbidity

Medical and psychiatric comorbidities present yet another challenge to the effective treatment of the older substance abuser. Comorbid conditions such as medical complications, cognitive impairment, mental disorders such as major depression, sensory deficits, and lack of mobility not only can complicate a diagnosis but can sway the provider from encouraging older patients to pursue treatment for their substance abuse problems.

Special Populations

Women, minorities, and those who are homebound, including adults with physical disabilities, confront more specific barriers to treatment:

- Compared with men, women have less insurance coverage and supplemental income (such as a pension). Older women are prescribed more and consume more psychoactive drugs, particularly benzodiazepines, than are men and are more likely to be long-term users of these substances.
- Racial and ethnic minorities may experience language barriers. Interpreters can bias communications. A clinician's lack of knowledge of the client's belief systems prevents effective diagnosis.
- Homebound adults may experience isolation and difficulties with transportation as well as handicapped accessibility.

Other Barriers to Identification and Treatment

Other barriers to treatment in the older population are:

- **Transportation:** This is especially problematic in rural communities that lack public transportation or in poor urban communities where accessing transportation can be dangerous (Fortney et al., 1995).
- **Shrinking social support network:** Fewer friends to support them, participate in the treatment process, or take them places.
- **Time:** Despite the assumption that older adults have an excess of free time, they may well have to provide 24-hour supervision to a spouse, other relative, or friend, or have to care for grandchildren while the parent works.
- **Lack of expertise:** Few programs have specialists in geriatrics, treat many older adults, or are designed to accommodate functional disabilities such as hearing loss or ambulation problems.

- **Financial:** The structure of insurance policies can be a barrier to treatment. The carving out of mental health services from physical health services under managed care in particular can prevent older adults from receiving inpatient substance abuse treatment.

Because of the increased potential for enhanced reactions to alcohol and to alcohol in combination with other drugs, it is important that clinicians, family members, and social service providers be on the lookout for signs of problems. Communities can implement "gatekeeper" systems, wherein meter readers, credit office workers, repair personnel, postal carriers, police, apartment managers, and others watch for and report signs of depression and other psychiatric disorders (often exacerbated by substance abuse).

Substance use disorders, if not diagnosed and treated, may ruin the last stage of life for countless Americans.

Chapter 2

Alcohol

Alcohol abuse and misuse are the major substance abuse problem among older adults. Currently, rates for alcohol-related hospitalizations among older patients are similar to those for heart attacks (Adams et al., 1993). Those rates vary greatly by geographic location, from 19 per 10,000 admissions in Arkansas to 77 per 10,000 in Alaska. As disturbing as these figures are, they probably represent a gross underestimation of the true problem. Studies consistently find that older adults are less likely to receive a primary diagnosis of alcoholism than are younger adults (Booth et al., 1992; Stinson et al., 1989; Beresford et al., 1988).

Alcohol and Aging

Adults over the age of 65 are more likely to be affected by at least one chronic illness, many of which can make them more vulnerable to the negative effects of alcohol consumption (Bucholz et al., 1995).

Three age-related changes significantly affect the way an older person responds to alcohol:

- Decrease in body water
- Increased sensitivity and decreased tolerance to alcohol
- Decrease in the metabolism of alcohol in the gastrointestinal tract.

Comorbidities

The interaction of age-related physiological changes and the consumption of alcohol can trigger or exacerbate additional serious problems among older adults, including

- Increased risk of hypertension, cardiac arrhythmia, myocardial infarction, and cardiomyopathy
- Increased risk of hemorrhagic stroke
- Impaired immune system and capability to combat infection and cancer

- Cirrhosis and other liver diseases
- Decreased bone density
- Gastrointestinal bleeding
- Depression, anxiety, and other mental health problems
- Malnutrition
- Sleep disturbances

Classifying Drinking Practices and Problems Among Older Adults

Physiological changes, as well as changes in the kinds of responsibilities and activities pursued by older adults, make established criteria for classifying alcohol problems largely irrelevant for this population.

Two classic models for understanding alcohol problems—the medical diagnostic model and the at-risk, heavy, and problem drinking classification—include criteria that may not adequately apply to many older adults and may lead to underidentification of drinking problems (Atkinson, 1990).

DSM-IV

Mental health providers use the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (DSM-IV) to diagnose—insurance payments are based on the book's classifications. However, the DSM-IV criteria may not apply to many older adults who experience neither the legal, social, nor psychological consequences specified. For example,

- "Failure to fulfill major role obligations at work, school, or home" is less applicable to a retired person with minimal familial responsibilities.
- "Continued use of the substance(s) despite persistent or recurrent problems" does not always apply.

- The thresholds of consumption often considered by clinicians as indicative of tolerance may be set too high for older adults because of their altered sensitivity to and body distribution of alcohol (Atkinson, 1990).
- Many late onset alcoholics have not developed physiological dependence, and they do not exhibit signs of withdrawal.

At-Risk, Heavy, and Problem Drinking

Although the distinction between the terms *heavy* and *problem* is meaningful to alcohol treatment specialists interested in differentiating severity of problems among younger alcohol abusers, it may have less relevance for older adults (Atkinson and Ganzini, 1994), who may experience pervasive consequences with less consumption due to their heightened sensitivity to alcohol or the presence of such coexisting diseases as diabetes mellitus, hypertension, cirrhosis, or dementia.

In general, the threshold for at-risk alcohol use decreases with advancing age. For many adults, the phenomenon of aging, with its accompanying physical vulnerabilities and distinctive psychosocial demands, may be the key risk factor for alcohol problems.

Age-Appropriate Levels of Consumption

In its *Physician's Guide to Helping Patients With Alcohol Problems*, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) offers recommendations for low-risk drinking. For individuals over the age of 65, NIAAA recommends "no more than one drink per day" (National Institute on Alcohol Abuse and Alcoholism, 1995). The Consensus Panel endorses that recommendation and the accompanying refinements presented below (Dufour et al., 1992):

- No more than one drink per day
- Maximum of two drinks on any drinking occasion (New Year's Eve, weddings)
- Somewhat lower limits for women

Risk Factors for Alcohol Abuse

- **Gender** — Studies indicate that older men are much more likely than older women to have alcohol-related problems (Myers et al., 1984; Atkinson, 1990; Bucholz et al., 1995).
- **Loss of Spouse** — Alcohol abuse is more prevalent among older adults who have been

separated or divorced and among men who have been widowed (Bucholz et al., 1995).

- **Other Losses** — As individuals age, they not only lose their spouse but also other family members and friends to death and separation. Retirement may mean loss of income as well as job-related social support systems and the structure and self-esteem that work provides. Other losses include diminished mobility (e.g., greater difficulty using public transportation where available, inability to drive or driving limited to the daylight hours, problems walking); impaired sensory capabilities, which may be isolating even when the elder is in physical proximity to others; and declining health due to chronic illnesses.
- **Health Care Settings** — High rates of alcoholism are consistently reported in medical settings, indicating the need for screening and assessment of patients seen for problems other than substance abuse (Douglass, 1984; Liberto et al., 1992; Adams et al., 1996).
- **Substance Abuse Earlier in Life** — A strong relationship exists between developing a substance use disorder earlier in life and experiencing a recurrence in later life. Some recovering alcoholics with long periods of sobriety undergo a recurrence of alcoholic drinking as a result of major losses or an excess of discretionary time (Atkinson and Ganzini, 1994).
- **Comorbid Psychiatric Disorders** — Estimates of primary mood disorder occurring in older alcohol abusers vary from 12 to 30 percent or more (Finlayson et al., 1988; Koenig and Blazer, 1996). Patients with severe cognitive impairment
- **Family History of Alcohol Problems** — There is substantial cumulative evidence that genetic factors are important in alcohol-related behaviors (Cotton, 1979).

Concomitant Substance Use

The substances most commonly abused by older adults besides alcohol are nicotine and psychoactive prescription medications.

Although there is little research on the abuse of other illicit substances (e.g., heroin, cocaine, and marijuana) by older adults, therapists and health care personnel are seeing more older adults who present with symptoms of illicit drug abuse.

Chapter 3

Use and Abuse of Prescription and Over-the-Counter Medications

Adults age 65 and older consume more prescribed and over-the-counter medications than any other age group in the United States. A large share of prescriptions for older adults are for psychoactive, mood-changing drugs that carry the potential for misuse, abuse, or dependency. Moreover, older adults are apparently more likely to continue use of psychoactive drugs for longer periods than their younger counterparts (Sheahan et al., 1995; Woods and Winger, 1995).

The most commonly prescribed abusable psychoactive medications for older adults are

- Benzodiazepines
- Antidepressants
- Opiate/opioid analgesics

Patterns of Use

The drug-taking patterns of psychoactive prescription drug users can be described as a continuum that ranges from appropriate use for medical or psychiatric indications through misuse by the patient or the prescribing health care practitioner to persistent abuse and dependence as defined by the DSM-IV (see Figure 3-1). Because older adults are less likely to use psychoactive medications nontherapeutically, problems with drugs generally fall into the misuse category and are unintentional. For example, older patients are more likely to misunderstand directions for appropriate

use—a problem compounded by the multiple prescriptions they receive, often from multiple physicians unaware of a colleague's treatments. In these circumstances, overdose, additive effects, and adverse reactions from combining drugs are more likely to occur.

Unintentional misuse can, however, progress into abuse if an older adult continues to use a medication nontherapeutically for the desirable effects it provides, much as an abuse of any drug does. Adults can become physiologically dependent on psychoactive medications without meeting dependence criteria. Tolerance and physical dependence can develop when some psychoactive medications are taken regularly at the therapeutically appropriate dose for relatively brief periods. In other words, adults can become dependent on psychoactive medications without realizing it.

Risk Factors for Misuse and Abuse of Psychoactive Drugs

A variety of factors influence the use and potential for misuse or abuse of psychoactive prescription drugs and over-the-counter medications by older adults., including

- Old age
- Poor physical health
- Female gender (Cooperstock and Parnell, 1982; Sheahan et al., 1989; Finlayson, 1995)

Figure 3-1
Continuum of Psychoactive Prescription Drug Use

Proper Use



Misuse

By Patient

- Dose level more or less than recommended
- Use for contraindicated purposes
- Use in conjunction with other medications with undesirable interactions
- Skipping doses/hoarding drugs
- Use with alcohol

By Doctor

- Prescribing unnecessarily high dose
- Prescribing without determining what other medication patient is taking
- Not clearly explaining regimen



Abuse

By Patient

- Use resulting in
 - ♦ Decline in work, school, or home performance
 - ♦ Legal problems
- Use in risky situations (e.g., driving while impaired)
- Continued use despite adverse social or interpersonal consequences

Source: American Psychiatric Association, 1994



Dependence

By Patient

- Use resulting in
 - ♦ Tolerance
 - ♦ Withdrawal symptoms
 - ♦ Decline in normal activities
 - ♦ Unsuccessful attempts or a desire to cut down or control use
- Use of a substance in larger amounts or for a longer period than was intended
- Use that consumes a lot of time (including time to acquire and use the drug and to recover from its effects)
- Continued use despite knowledge that it has caused or aggravated a physical or psychological problem

Source: American Psychiatric Association, 1994

Chapter 4

Identification, Screening, and Assessment

Because older adults are less likely to be diagnosed and receive the screening, assessment, and intervention they need, the whole community must help identify the problem. Providers of social services, health care, and others who interact daily with older adults should engage in multitiered, nontraditional case-finding methods (Raschko, 1990; DeHart and Hoffmann, 1995).

Screening

Barriers to Screening

Barriers to screening include

- Ageist assumptions
- Failure to recognize symptoms
- Lack of knowledge about screening
- Masking of symptoms by concurrent illnesses and chronic conditions

Finally, many health care and social service providers are unaware that effective, validated instruments are available for screening older adults and that many screens take only a few minutes to administer and require little or no specialized training to score and interpret. Screening instruments are discussed in more detail below.

Who and When To Screen

Ideally, every 60-year-old should be screened for alcohol and prescription drug abuse as part of his or her regular physical examination. Although no hard-and-fast rules govern the timing of screening, the Panel recommends screening or rescreening if the physical symptoms listed in Figure 4-1 are present or if the older person is undergoing major life changes or transitions such as those discussed below.

As older patients undergo key life transitions or take on new and stressful roles, vulnerability to alcohol or prescription drugs increases. Risk factor life transitions include menopause, a newly "empty nest," and approaching retirement. Assuming new

roles such as caretaker for an ailing relative or custodian of young grandchildren also makes older adults more vulnerable. Any of these changes should trigger an alcohol screen.

Introducing the Topic of Screening

Depending on the setting, the topic of screening can be introduced in a number of ways:

- Self-administered and self-scored mass screenings can be a part of a larger presentation
- Visiting nurses and home health aides can integrate a brief alcohol screen into the list of health questions normally posed to patients
- Friendly visitors, Meals-On-Wheels volunteers, caretakers, and health care providers can interject screening questions into their normal conversations with older, homebound adults.

Anyone who is concerned about an older adult's drinking practices can try asking direct questions, such as

- "Do you ever drink alcohol?"
- "How much do you drink when you do drink?"
- "Do you ever drink more than four drinks on one occasion?"
- "Do you ever drink and drive?"
- "Do you ever drink when you're lonely or upset?"
- "Does drinking help you feel better [or get to sleep more easily, etc.]? How do you feel the day after you have stopped drinking?"
- "Have you ever wondered whether your drinking interferes with your health or any other aspects of your life in any way?"
- "Where and with whom do you typically drink?" (Drinking at home alone signals at-risk or potentially abusive drinking.)
- "How do you typically feel just before your first drink on a drinking day?"
- "Typically, what is it that you expect when you think about having a drink?" (Note: Positive

Figure 4-1 Physical Symptom Screening Triggers

- Sleep complaints; observable changes in sleeping patterns; unusual fatigue, malaise, or daytime drowsiness; apparent sedation (e.g., a formerly punctual older adult begins oversleeping and is not ready when the senior center van arrives for pickup)
- Cognitive impairment, memory or concentration disturbances, disorientation or confusion (e.g., family members have difficulty following an older adult's conversation, the older adult is no longer able to participate in the weekly bridge game or track the plot on daily soap operas)
- Seizures, malnutrition, muscle wasting
- Liver function abnormalities
- Persistent irritability (without obvious cause) and altered mood, depression, or anxiety
- Unexplained complaints about chronic pain or other somatic complaints
- Incontinence, urinary retention, difficulty urinating
- Poor hygiene and self-neglect
- Unusual restlessness and agitation
- Complaints of blurred vision or dry mouth
- Unexplained nausea and vomiting or gastrointestinal distress
- Changes in eating habits
- Slurred speech
- Tremor, motor uncoordination, shuffling gait
- Frequent falls and unexplained bruising

expectations or consequences of alcohol use in the presence of negative affect and inadequate coping skills have been associated with problem drinking.)

If less direct questioning seems appropriate, other useful questions for identifying problematic alcohol or prescription drug use include

- "Are you having any medical or health problems? What symptoms do you have? What do you think these mean? Have you felt this way before?"
- "Do you see a doctor or other health care provider regularly? When was the last time? Do you see more than one? Why? Have you switched doctors recently? Why?"
- "Have you experienced any negative or unwanted events that altered the way you lived (in the last 5 years)? Any since we last met? How much of an impact did the event have on the way you lived or felt? What feelings or beliefs did it cause or change? Do you believe that you are coping with the changes in a healthy fashion? How (specifically) do you manage (control) the circumstances (consequences) of the problem(s) or event(s)?"
- "What prescription drugs are you taking? Are you having any problems with them? May I see them?" (This question will need to be followed by an examination of the actual containers to ascertain the drug name, prescribed dose, expiration date, prescribing physician, and pharmacy that filled each prescription. Note whether there are any psychoactive medications. Ask the patient to bring the drugs in their original containers.)
- "Where do you get prescriptions filled? Do you go to more than one pharmacy? Do you receive and follow instructions from your doctor or pharmacist for taking the prescriptions? May I see them? Do you know whether any of these medicines can interact with alcohol or your other prescriptions to cause problems?"
- "Do you use any over-the-counter drugs (non-prescription medications)? If so, what, why, how much, how often, and how long have you been taking them?"

Nonmedical caretakers, volunteers, and aides may opt to ask only the four questions in the CAGE Questionnaire (Ewing, 1984):

1. Have you ever felt you should **cut down** on your drinking?
2. Have people **annoyed** you by criticizing your drinking?
3. Have you ever felt bad or **guilty** about your drinking?
4. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (**eye opener**)?

If the older adult answers yes to any of the four, refer to a clinician for evaluation. Other warning signs that may emerge in conversation and should prompt a more in-depth screen or an assessment include

- Excessively worrying about whether prescription psychoactive drugs are “really working” to alleviate numerous physical complaints; complaints that the drug prescribed has lost its effectiveness over time (evidence of tolerance)
- Displaying detailed knowledge about a specific psychoactive drug and attaching great significance to its efficacy and personal impact
- Worrying about having enough pills or whether it is time to take them to the extent that other activities revolve around the dosage schedule
- Continuing to use and to request refills when the physical or psychological condition for which the drug was originally prescribed has or should have improved (e.g., prescription of sleeping pills after the death of a loved one); resisting cessation or decreasing doses of a prescribed psychoactive drug
- Complaining about doctors who refuse to write prescriptions for preferred drugs, who taper dosages, or who don’t take symptoms seriously
- Self-medicating by increasing doses of prescribed psychoactive drugs that aren’t “helping anymore” or supplementing prescribed drugs with over-the-counter medications of a similar type
- Rating social events by the amount of alcohol dispensed
- Eating only at restaurants that serve alcoholic beverages (and wanting to know whether they do in advance)
- Withdrawing from family, friends, and neighbors
- Withdrawing from normal and life-long social practices
- Cigarette smoking
- Involvement in minor traffic accidents (police do not typically suspect older adults of alcohol abuse and may not subject them to Breathalyzer™ and other tests for sobriety)

- Sleeping during the day
- Bruises, burns, fractures, or other trauma, particularly if the individual does not remember how and when they were acquired
- Drinking before going to a social event to “get started”; gulping drinks, guarding the supply of alcoholic beverages, or insisting on mixing own drinks
- Changes in personal grooming and hygiene
- Expulsion from housing
- Empty liquor, wine, or beer bottles or cans in the garbage or concealed under the bed, in the closet, or in other locations.

Asking Screening Questions

Screening questions should be asked in a confidential setting and in a nonthreatening, nonjudgmental manner. Many older adults are acutely sensitive to the stigma associated with alcohol and drug abuse and are far more willing to accept a “medical” as opposed to a “psychological” or “mental health” diagnosis as an explanation for their problems. Prefacing questions with a link to a medical condition can make them more palatable. For example, “I’m wondering if alcohol may be the reason why your diabetes isn’t responding as it should,” or, “Sometimes one prescription drug can affect how well another medication is working. Let’s go over the drugs you’re taking and see if we can figure this problem out.” It is vitally important to avoid using stigmatizing terms like *alcoholic* or *drug abuser* during these encounters.

Another technique that may help when talking with older adults is *active listening* (Egan, 1994). The four components of active listening are

1. Observing and reading the person’s nonverbal behavior—posture, facial expressions, movement, and tone of voice
2. Listening to and understanding the person’s verbal communication
3. Listening in context, that is, to the whole person in the context of the social settings of his or her life
4. Listening to sour notes, that is, things the person says that may have to be challenged.

Motivational interviewing is nonconfrontational, egalitarian, and supportive. When screening anyone, especially older adults, empathy is crucial. However, in attempting to be nonconfrontational and circumspect, it is also important to avoid using euphemisms that minimize the problem.

Cognition and Collateral Reporting

Impaired cognition interferes with screening, making it difficult to obtain complete and accurate answers. Although it is important to respect the older adult's autonomy, collateral participation from family members or friends may be necessary in situations where a coherent response is unlikely. In this case, the screener should first ask for the older adult's permission to question others on his or her behalf.

Screening Instruments

The CAGE Questionnaire and the Michigan Alcoholism Screening Test—Geriatric Version (MAST-G) (Blow et al., 1992) are two well-known alcohol screening instruments that have been validated for use with older adults. Before administering the CAGE, the MAST-G, or any other screen, ascertain that the person does currently drink alcohol and that the questions that are endorsed are for problems that they have experienced recently, usually within the last year.

The MAST-G was developed specifically for older adults (see Figure 4-2) and has high sensitivity and specificity among older adults recruited from a wide range of settings, including primary care clinics, nursing homes, and older adult congregate housing locations.

Although the Alcohol Use Disorders Identification Test (AUDIT) (Babor et al., 1992) has not been evaluated for use with older adults, it has been validated cross-culturally. Because there are few culturally sensitive screening instruments, the AUDIT (in the opinion of the Consensus Panel) may prove useful for identifying alcohol problems among older members of ethnic minority groups (see Appendix A).

Communicating Positive Screening Results

To ease the process of communicating positive screening results to older patients, the Panel recommends the following approach:

- Describe the impact that alcohol or prescription drug abuse is having on the older adult's health or functional status: "The screening results indicate that alcohol may be having a negative effect on your blood pressure."
- Immediately follow up by noting: "This is very treatable. Cutting down on the amount you drink" or "giving up drinking altogether" or "reducing your use of chlorthalidone (Librium)" or "using other methods to help you sleep . . . will help you maintain your inde-

pendence" or "help keep you out of a nursing home" or "decrease the likelihood of future hip fractures" or "keep you from getting so confused." In other words, spell out how reduction or cessation of use will improve the person's life. Most problem drinkers cannot address their problems by reducing use, so emphasize the importance of abstinence by saying something like: "Though I strongly recommend you stop altogether, cutting down is a good start."

- Present the options for addressing the problem: If the problem seems severe, "I'd like to do a complete assessment (or refer you to someone for assessment) so we know how to proceed"; or if the problem appears to be in the early stages of development, "I'd like to see you change your drinking habits to no more than one beer (drink) per day. We'll monitor your progress over the next few weeks and see if this will help with your hypertension." This is a good time to explore the patient's willingness to change by adding, for example, "Would you be willing to change your drinking habits if the other problems we have discussed improve?"
- Occasionally, a situation may appear dire, and the clinician suspects that the older adult needs to be detoxified. In this case, admission to an inpatient unit for detoxification may be the most prudent choice. Referral to an outpatient detoxification center that can monitor the person daily is appropriate if there is social support at home.

Before discussing results with an older adult, clinicians must be prepared with information about community resources available to assist in coping with this problem (e.g., meeting dates, times, and locations of Alcoholics Anonymous and other self-help recovery groups whose membership is largely 55 and older; contact and eligibility information for treatment programs that respond to the special needs of older adults); the older adult's available supports (e.g., Is transportation available? Is the recommended program affordable or covered by insurance?); and the older adult's special needs (e.g., Is the program bilingual or wheelchair accessible?). A strategy for responding to denial or refusal to follow through with a plan of action should be in place. With the agreement of an older adult involved in a self-help group or treatment program, clinicians can broker an introduction to a peer "who's been there." Frequently, these "veterans" will accompany prospective members to meetings and mentor them through the treatment process.

Figure 4-2
Michigan Alcoholism Screening Test—Geriatric Version (MAST-G)

| | | |
|---|-----|----|
| 1. After drinking have you ever noticed an increase in your heart rate or beating in your chest? | YES | NO |
| 2. When talking with others, do you ever underestimate how much you actually drink? | YES | NO |
| 3. Does alcohol make you sleepy so that you often fall asleep in your chair? | YES | NO |
| 4. After a few drinks, have you sometimes not eaten or been able to skip a meal because you didn't feel hungry? | YES | NO |
| 5. Does having a few drinks help decrease your shakiness or tremors? | YES | NO |
| 6. Does alcohol sometimes make it hard for you to remember parts of the day or night? | YES | NO |
| 7. Do you have rules for yourself that you won't drink before a certain time of the day? | YES | NO |
| 8. Have you lost interest in hobbies or activities you used to enjoy? | YES | NO |
| 9. When you wake up in the morning, do you ever have trouble remembering part of the night before? | YES | NO |
| 10. Does having a drink help you sleep? | YES | NO |
| 11. Do you hide your alcohol bottles from family members? | YES | NO |
| 12. After a social gathering, have you ever felt embarrassed because you drank too much? | YES | NO |
| 13. Have you ever been concerned that drinking might be harmful to your health? | YES | NO |
| 14. Do you like to end an evening with a nightcap? | YES | NO |
| 15. Did you find your drinking increased after someone close to you died? | YES | NO |
| 16. In general, would you prefer to have a few drinks at home rather than go out to social events? | YES | NO |
| 17. Are you drinking more now than in the past? | YES | NO |
| 18. Do you usually take a drink to relax or calm your nerves? | YES | NO |
| 19. Do you drink to take your mind off your problems? | YES | NO |
| 20. Have you ever increased your drinking after experiencing a loss in your life? | YES | NO |
| 21. Do you sometimes drive when you have had too much to drink? | YES | NO |
| 22. Has a doctor or nurse ever said they were worried or concerned about your drinking? | YES | NO |
| 23. Have you ever made rules to manage your drinking? | YES | NO |
| 24. When you feel lonely, does having a drink help? | YES | NO |

Scoring: Five or more "yes" responses are indicative of an alcohol problem. For further information, contact Frederic C. Blow, Ph.D., at University of Michigan Alcohol Research Center, 400 E. Eisenhower Parkway, Suite A, Ann Arbor, MI 48108; (734) 998-7952.

Source: Blow, F.C.; Brower, K.J.; Schulenberg, J.E.; Demo-Dananberg, L.M.; Young, J.P.; and Beresford, T.P. The Michigan Alcoholism Screening Test—Geriatric Version (MAST-G): A new elderly-specific screening instrument. *Alcoholism: Clinical and Experimental Research* 16:372, 1992.

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For some older adults coming to grips with an alcohol or prescription drug problem, repeated contacts would be necessary before they are willing to cooperate with a referral. Clinicians have observed that this process is akin to planting and nurturing a seed. Bringing the seed to fruition, however, ultimately depends on the older adult.

Communicating Negative Screening Results

The process of conveying negative screening results provides an important opportunity to reinforce healthy practices and educate older adults about the impact that alcohol and prescription drugs have on aging systems. Life events render older adults vulnerable to developing problems; as the changes occur, screening questions should be asked again and the benefits of maintaining healthy habits reemphasized.

Assessment

For older adults with positive screens, an assessment is needed to confirm the problem, to characterize the dimensions of the problem, and to develop an individualized treatment plan. For purposes of insurance or other funding resources, the assessment should follow criteria in the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (DSM-IV) (American Psychiatric Association, 1994) or other relevant criteria, bearing in mind that these criteria may not apply directly to planning older adults' treatment. The unqualified application of such criteria is problematic in older adult populations because the symptoms of other medical diseases and psychiatric disorders overlap to a considerable extent with substance-related disorders.

Because the assessment process can be time-consuming and expensive, the Institute of Medicine (IOM) recommends (and the Panel supports) a sequential approach that looks at various dimensions of an older adult's suspected problem in stages so that unnecessary tests are not conducted (Institute of Medicine, 1990).

Substance Abuse Assessment Instruments

Based on their experience, the Consensus Panelists recommend the use of two structured assessments with older adults: the Structured Clinical Interview for DSM-III-R (SCID) (Spitzer and Williams, 1985) and the Diagnostic Interview Schedule (DIS) for DSM-IV (Robins et al., 1981).

The SCID is a multimodule assessment that covers

- Substance use disorders
- Psychotic disorders
- Mood disorders
- Anxiety disorders
- Somatoform disorders
- Eating disorders
- Adjustment disorders
- Personality disorders.

It takes a trained clinician approximately 30 minutes to administer the 35 SCID questions that probe for alcohol abuse or dependence.

The DIS is a highly structured interview that does not require clinical judgment and can be used by nonclinicians. The DIS assesses both current and past symptoms and is available in a computerized version. It has been translated into a number of languages including Spanish and Chinese.

Special Assessments

For some older adults, it may be impossible to understand the true impact of their alcohol and drug use or to recommend appropriate treatment services without a full assessment of their physical, mental, and functional health.

Assessing Functional Abilities

Functional health refers to a person's capacity to perform two types of everyday tasks: activities of daily living (ADLs), which include ambulating, bathing, dressing, feeding, and using the toilet, and instrumental activities of daily living (IADLs), which include managing finances, preparing meals, shopping, taking medications, and using the phone. Limitations in these domains, sometimes referred to as *disabilities*, can result in an inadequate diet, mismanagement of medications or finances, or other serious problems. These disabilities are major risk factors for institutionalization and are more likely than physical illness or mental health problems to prompt older adults to seek treatment.

Alcohol use can diminish IADLs and ADLs. Although alcohol-related functional impairments are potentially reversible, they should be considered when planning a treatment regimen.

To identify functional impairments, the Panel recommends measuring the ADLs and the IADLs with the instruments in Appendix A. Another useful instrument is the Medical Outcomes Study 36-Item Short Form Health Survey (SF-36), a self-

report questionnaire that measures health-related quality of life, including both ADLs and IADLs (McHorney et al., 1994).

Assessing Comorbid Disorders

The relationship between alcohol use and a coexisting physical or mental disorder can take many different forms. At one extreme, medical and psychiatric problems can coexist with alcohol use with no specific relationship to drinking. Alternatively, those problems may be precipitating or maintenance factors for drinking.

The existence of comorbid medical and psychiatric disorders will influence treatment choice and priorities and will affect treatment outcome.

Physical comorbidities

Physical comorbidities often include

- Alcoholic liver disease
- Malnutrition
- Dehydration

Acute alcohol withdrawal syndrome is more protracted and severe in older adults than in younger adults (Brower et al., 1994; Liskow et al., 1989). Because there is no research on the recent practice of outpatient detoxification for older adults, very careful assessment is warranted before detoxification from any drug; outpatient detoxification may not be appropriate for older adults who are frail or who have a comorbidity.

Psychiatric comorbidities

Comorbid disorders associated with alcohol use include

- Anxiety disorders
- Affective illness
- Cognitive impairment
- Schizophrenia
- Antisocial personality disorder

Cognitive impairments

The presence of cognitive impairment or dementia significantly alters treatment decisions. It is particularly important to distinguish between dementia and delirium, which are often mistaken for each other by clinicians diagnosing older patients.

Dementia is a chronic, progressive, and generally irreversible cognitive impairment sufficient to interfere with an individual's daily living. Dementia will also limit an individual's ability to interact in traditional group settings. Common

causes of dementia include Alzheimer's disease, vascular disorders (e.g., multi-infarct dementia), and alcohol-related dementia. Dementia also makes it more difficult to monitor outcomes of drinking (patients may forget they drank), to get into treatment, and to benefit from the treatment.

Delirium is a potentially life-threatening illness that requires acute intervention—usually hospitalization. The cognitive losses experienced with delirium, unlike the effects of dementia, can often be reversed with proper medical treatment.

Other cognitive impairments

Alcohol abuse and dependence are directly correlated with other potential causes of cognitive impairment, including trauma from falls, motor vehicle crashes or other accidents, and the development of Wernicke-Korsakoff syndrome (Smith and Atkinson, 1997).

Other psychiatric disorders

It helps if significant others, clergy, social workers, and home health care providers are knowledgeable about the warning signs for suicide, because these symptoms are more frequently manifested in non-clinical settings.

Moving the Older Adult Into Treatment

After determining that an older adult may benefit from a reduction in or complete abstinence from alcohol use, the clinician must next assess the patient's understanding of this benefit.

Interacting With Older Adults

Many health care professionals rarely interact with older adults. To facilitate the assessment process with this population, the Consensus Panel recommends that clinicians adhere to the following guiding principles:

- Areas of concern most likely to motivate older substance abusers are their physical health, the loss of independence and function, financial security, and maintenance of independence.
- Assessment and treatment decisions must include the patient in order to be successful. This is particularly relevant for older adults, who may be very uncomfortable in formalized addiction treatment programs that do not include many of their peers or address their specific developmental and health needs.

- Depending on an individual's particular situation, it may be important to include family members in treatment or intervention discussions (understanding that children may vacillate between a desire to help and denial and that patient confidentiality must always be respected).
- Addiction is a chronic illness that ebbs and flows. Thus, patients' needs will change over time and will require different types and intensities of treatment.
- Because many older adults have several health care providers (e.g., visiting nurses, social workers, adult day care staff, religious personnel), it is important to include this network as a resource in assessment and in providing treatment.
- Given the complex health needs of older adults, health care providers may need assistance from experienced nonmedical personnel to adequately assess the totality of treatment issues and choices. Providers should be aware of their limitations both in providing addiction treatment and in assessing and treating mental or physical health needs.
- All treatment strategies must be culturally competent and, to the extent possible, incorporate appropriate ethnic considerations (e.g., religious rituals).
- Overarching continuity of care issues and considerations should be identified and addressed, especially in rural and minority communities where emergency room staff function as primary care providers.

Chapter 5

Referral and Treatment Approaches

Once screening and assessment have identified a problem, the clinician and patient must choose the most appropriate treatment. The Consensus Panel recommends that the least intensive treatment options be explored first: *brief intervention, intervention, and motivational*.

Least Intensive Options

Brief Intervention

A brief intervention is one or more counseling sessions that may include motivation-for-change strategies, patient education, assessment and direct feedback, contracting and goal setting, behavioral modification techniques, and the use of written materials such as self-help manuals (Fleming et al., 1997b).

Brief intervention strategies range from relatively unstructured counseling and feedback to more formal structured therapy and rely heavily on concepts and techniques from the motivational psychology and behavioral self-control training literature (Miller and Taylor, 1980; Miller and Hester, 1986; Miller and Munoz, 1976; Miller and Rollnick, 1991). The goal is to motivate the problem drinker to change his behavior, not to assign blame. Drinking goals accordingly should be flexible, allowing the individual to choose drinking in moderation or abstinence.

Older adults present unique challenges to those applying brief intervention strategies for reducing alcohol consumption. Because many older at-risk and problem drinkers are ashamed about their drinking, intervention strategies need to be especially nonconfrontational and supportive.

Following identification of at-risk or problem drinkers through screening techniques described in Chapter 4, a semistructured brief intervention can

be conducted. An older adult-specific brief intervention should include the following steps:

- Customized feedback on patient's responses to screening questions about drinking patterns and other health habits such as smoking and nutrition.
- Discussion of types of drinkers and where the patient's drinking patterns fit into the population norms for his or her age group.
- Reasons for drinking. This is particularly important because the practitioner needs to understand the role of alcohol in the context of the older patient's life, including coping with loss and loneliness.
- Consequences of heavier drinking. Some older patients may experience problems in physical, psychological, or social functioning even though they are drinking below cutoff levels.
- Reasons to cut down or quit drinking. Maintaining independence, physical health, financial security, and mental capacity can be key motivators in this age group.
- Sensible drinking limits and strategies for cutting down or quitting. Strategies that are useful in this age group include developing social opportunities that do not involve alcohol, getting reacquainted with hobbies and interests from earlier in life, and pursuing volunteer activities, if possible.
- Drinking agreement in the form of a contract. Agreed-upon drinking limits that are signed by the patient and the practitioner are particularly effective in changing drinking patterns.
- Coping with risky situations. Social isolation, boredom, and negative family interactions can present special problems in this age group.
- Summary of the session.

One approach devised to facilitate brief interventions is known by the acronym FRAMES. The FRAMES approach emphasizes

- **Feedback** of personal risk or impairment as derived from the assessment
- Personal **responsibility** for change
- Clear **advice** to change
- A **menu** of change options to increase the likelihood that an individual will find a responsive treatment (although multiple attempts may be necessary)
- An **empathic** counseling style
- Enhanced client **self-efficacy** and ongoing follow-up (Miller and Sanchez, 1994).

Key to inspiring motivation is the clinician's caring style, willingness to view the older adult as a full partner in his or her recovery, and capacity to provide hope and encouragement as the older adult progresses through the referral, treatment, and recovery process.

Intervention and Motivational Counseling

If the older problem drinker does not respond to the brief intervention, two other approaches—intervention and motivational counseling—should be considered.

Intervention

In an intervention, which occurs under the guidance of a skilled counselor, several significant people in a substance abuser's life confront the individual with their firsthand experiences of his or her drinking or drug use (Johnson, 1973; Twerski, 1983). The formalized process begins before the intervention and includes a progressive interaction between the counselor and the family or friends for at least 2 days before meeting with the patient. During this time, the counselor not only helps plan the intervention but also educates the family about substance abuse and its prevention (Johnson, 1973). Participants are coached about offering information in an emotionally neutral, factual manner while maintaining a supportive, nonaccusatory tone, thus presenting incontrovertible evidence to the loved one that a problem exists.

When using this approach with older adults, Panel members recommend that no more than one or two relatives or close associates should be involved along with the counselor; having too

many people present may be emotionally overwhelming or confusing for the older person. The most influential person to include in interventions or any other pretreatment activity may be a spouse, cohabitant, caregiving son or daughter, clergy member, or visiting nurse or caseworker, depending on the particular social network of the client. Inclusion of grandchildren is discouraged: Panel members report that many older alcoholics describe long-lasting resentment and shame about the airing of their problems in the presence of much younger relatives.

Because denial is as much a part of psychoactive prescription drug dependence as it is of alcoholism and addiction to illicit drugs, an intervention may help move psychoactive drug abusers toward detoxification or other formal treatment, although extra caution is advisable. Both the diagnosis of abuse or dependence and the need for treatment are particularly difficult for older patients to accept because their initial use of psychoactive prescription drugs was, in almost all cases, originally sanctioned by a health care provider and prescribed as a remedy for a legitimate medical problem or complaint. As a group, older adults tend to have even greater disdain for "drug addicts" than the general population: Any implied linkage with the criminalized population of illicit drug users is unnecessarily stigmatizing and appropriately resented. Such labels as addict, alcoholic, and drunkard should be avoided.

Motivational counseling

Research on stages of change, initially applied to smoking cessation studies, has demonstrated that smokers enrolled in treatment trials fall into one of five stages: precontemplation, contemplation, ready for action, action, and maintenance (Prochaska and DiClemente, 1986). Categorizing smokers this way helps predict who is most likely to succeed in quitting smoking and what kinds of interventions work best with smokers in different stages (DiClemente et al., 1991; Prochaska and DiClemente, 1985; Velicer et al., 1992). More recently, it has been suggested that research on brief interventions for problem drinkers could examine stages of change as a means of tailoring interventions to an individual's readiness (Hodgson and Rollnick, 1992).

Motivational counseling acknowledges differences in readiness and offers an approach for "meeting people where they are" that has proven effective with older adults (Miller and Rollnick, 1991).

Specialized Treatment of Older Problem Drinkers and Substance Abusers

For some older adults, especially those who are late onset drinkers or prescription drug abusers with strong social supports and no mental health comorbidities, pretreatment approaches may prove quite effective, and followup brief interventions and empathic support for positive change may be sufficient for continued recovery. There is, however, a subpopulation of older adults who will need more intensive treatment.

Despite the resistance that some older problem drinkers or drug abusers exert, treatment is worth pursuing. Studies show that older adults are more compliant with treatment and have treatment outcomes as good as or better than those of younger patients (Oslin et al., 1997; Atkinson, 1995).

Patient Placement and Patient Matching

Triage refers to the process of organizing and prioritizing treatment service. Typically, decisions regarding triage are made up of two components: patient placement and patient matching.

Patient placement describes a process by which a recommendation is made for placement in a specific level (intensity) of care, which ranges from medically managed (high intensity) inpatient services to outpatient services (low intensity). The most commonly used patient placement criteria are found in the American Society of Addiction Medicine (ASAM) *Patient Placement Criteria for the Treatment of Substance-Related Disorders*, Second Edition (ASAM-PPC-2) (American Society of Addiction Medicine, 1996).

Levels of Treatment Services

Inpatient/Outpatient Detoxification Treatment

One of the first issues to consider for an older patient with a substance dependence diagnosis is whether detoxification management is necessary and, if so, whether it should be undertaken in an inpatient hospital-based setting or managed on an outpatient basis.

Factors indicating the need for inpatient detoxification include

- A high potential for developing dangerous abstinence symptoms such as a seizure or

delirium because (1) the dosage of alcohol or drug has been particularly high or prolonged and has been discontinued abruptly or (2) the patient has experienced these serious symptoms at any time previously

- Suicidal ideation or threats
- The presence of other major psychopathology
- Unstable or uncontrolled comorbid medical conditions requiring 24-hour care or parenterally administered medications (e.g., renal disease, diabetes)
- Mixed addictions (e.g., alcohol, sedative/hypnotic drugs)
- A lack of social supports at home or living alone with continued access to the abused substance(s)
- A failure to respond to outpatient treatment

Inpatient Rehabilitation

Patients who are brittle, frail, acutely suicidal, or medically unstable or who need constant one-on-one monitoring, should receive 24-hour primary medical/psychiatric/nursing inpatient care in medically managed and monitored intensive treatment settings. Recent changes in the health care system have dramatically reduced the availability of this level of care. Inpatient rehabilitation (traditional 14-, 21-, or 28-day programs) are not readily available and often no longer reimbursed by health care insurers. Because of these reimbursement gaps, inpatient care may have to be arranged on a medical or psychiatric unit of an acute care hospital.

Residential Rehabilitation

Residential programs provide a slower paced, more repetitive treatment approach for older patients. Services range from high to low intensity and can be delivered in specialized care settings (e.g., halfway house, group home for people with addiction problems, board and care facilities, domiciliary facilities for veterans) and in nonspecialized settings (e.g., extended care facilities, life care programs, subacute nursing homes where primary care doctors make rounds and visiting nurses attend occasionally). These facilities help stabilize care for patients who lack significant social resources (local friends and family) and for those with no mobility.

Outpatient Services

Specialized outpatient programs vary greatly in the intensity of treatment. Partial hospitalization/day

treatment programs require patients to attend day-long treatment 5 days per week, whereas intensive outpatient programs are sometimes hospital-based and provide 2 to 3 hours of treatment each day. Finally, traditional low-intensity outpatient care normally provides for one group session per week and one individual session per month.

Specialized outpatient treatment generally includes psychiatric consultation and individualized or group psychotherapy. Outpatient programs frequently encourage patients to attend regular meetings of self-help groups like Alcoholics Anonymous and often assign a proactive case manager to help an older patient connect with an appropriate group. After a patient's release from an outpatient substance abuse treatment program, a case manager plays an important aftercare role by coordinating community-based support and monitoring to reinforce gains made during treatment and prevent or minimize the impact of slips.

Program Philosophy and Basic Principles

Although the success of treatment for older adults has been documented, health care providers should carefully consider a program's philosophy and practices regarding older clients. The Consensus Panel recommends incorporating the following six features into treatment of the older alcohol abuser (Schonfeld and Dupree, 1996):

1. Age-specific group treatment that is supportive and nonconfrontational and aims to build or rebuild the patient's self-esteem
2. A focus on coping with depression, loneliness, and loss (e.g., death of a spouse, retirement)
3. A focus on rebuilding the client's social support network
4. A pace and content of treatment appropriate for the older person
5. Staff members who are interested and experienced in working with older adults
6. Linkages with medical services, services for the aging, and institutional settings for referral into and out of treatment, as well as case management.

Building from these six features, the Consensus Panel recommends that treatment programs adhere to the following principles:

- Treat older adults in age-specific settings where feasible
- Create a culture of respect for older clients

- Take a broad, holistic approach to treatment that emphasizes age-specific psychological, social, and health problems
- Keep the treatment program flexible
- Adapt treatment as needed in response to clients' gender.

Holistic Treatment Based on Age-Specific Problems

Treatment programs are generally advised to take a broad, holistic approach. In treating the older substance abuser in particular, it is necessary to focus on more than just the drinking or substance abuse problem. A number of interrelated emotional, social, medical, spiritual, and practical problems or changes characterize the older adult's experiences (see Figure 5-1). Some of these can precipitate abuse of alcohol or other drugs. Those that initiate, sustain, or interact with the substance abuse problem provide the focus of a holistic treatment approach tailored to the needs of the individual.

Discussing life changes with patients can help them develop insight into the causes of their substance abuse problems. For example, while discussing salient nondrinking problems with an older adult, the drinking problem often emerges naturally as a topic of discussion. Although the problems associated with aging can be overwhelming, patients need not accept them passively. They can develop a self-care skill or positive attitude and can obtain appropriate help, such as the pharmacological alleviation of pain, management of grief, or skills for improving relationships.

Program Flexibility

The goals, setting, and duration of treatment may involve

- Finding safe, affordable housing
- Resolving depression
- Improving relationships with a caregiving son or daughter

It may be necessary to stop treatment when illnesses or hospitalization intervene. Schedule adjustments may be needed in recognition of the fatigue levels of older clients. The setting of treatment may need to shift from clinic to home during a period of convalescence from a hip fracture or an illness. One client may need twice as many treatment sessions to master steps toward self-sufficiency as another client. One individual may need to continue treatment for 2 years to meet the goals another client reaches within 6 months.

Figure 5-1
Life Changes Associated With Substance Abuse in Older Adults

| <i>Emotional and Social Problems</i> | |
|--|---|
| <ul style="list-style-type: none"> ■ Bereavement and sadness ■ Loss of <ul style="list-style-type: none"> ◆ Friends ◆ Family members ◆ Social status ◆ Occupation and sense of professional identity ◆ Hopes for the future ◆ Ability to function | <ul style="list-style-type: none"> ■ Consequent sense of being a “nonperson” ■ Social isolation and loneliness ■ Reduced self-regard or self-esteem ■ Family conflict and estrangement ■ Problems in managing leisure time/boredom ■ Loss of physical attractiveness (especially important for women) |
| <i>Medical Problems</i> | |
| <ul style="list-style-type: none"> ■ Physical distress ■ Chronic pain ■ Physical disabilities and handicapping conditions ■ Insomnia | <ul style="list-style-type: none"> ■ Sensory deficits <ul style="list-style-type: none"> ◆ Hearing ◆ Sight ■ Reduced mobility ■ Cognitive impairment and change |
| <i>Practical Problems</i> | |
| <ul style="list-style-type: none"> ■ Impaired self-care ■ Reduced coping skills ■ Decreased economic security or new poverty status due to <ul style="list-style-type: none"> ◆ Loss of income ◆ Increased health care costs | <ul style="list-style-type: none"> ■ Dislocation <ul style="list-style-type: none"> ◆ Move to new housing, or family moves away ◆ Homelessness ◆ Inadequate housing |

Gender Issues

Some women patients may be better served by all-female treatment groups and facilities.

Gender-related issues include

- Older women defer more to men and may take subservient roles in a treatment group.
- Older women could be less likely to become leaders in the group, thus failing to build their self-esteem.
- Both women and men may have personal issues related to their drinking that they would be reluctant to discuss with, or in the presence of, members of the opposite sex.

Treatment Approaches

The Consensus Panel recommends the following general approaches for effective treatment of older adult substance abusers:

- Cognitive-behavioral approaches
- Group-based approaches
- Individual counseling
- Medical/psychiatric approaches
- Marital and family involvement/family therapy
- Case management/community linked services and outreach

Figure 5-2 lists the major treatment objectives recommended for older substance abusers and the approaches that can best accomplish them.

Figure 5-2
Treatment Objectives and Approaches

| General Objectives/Examples | General Approaches/Examples |
|--|--|
| Eliminate or reduce substance abuse | Cognitive-behavioral (group or individual) <ul style="list-style-type: none"> ■ Alcohol (drug) effects ■ Relapse prevention ■ Stress management Group approaches <ul style="list-style-type: none"> ■ Alcohol (drug) effects education Medical <ul style="list-style-type: none"> ■ Naltrexone, acamprosate (alcohol) |
| Safely manage intoxication episodes during treatment | Medical <ul style="list-style-type: none"> ■ Remove patient from activities and observe ■ Link and refer to detoxification program |
| Enhance relationships | Cognitive-behavioral (group or individual) <ul style="list-style-type: none"> ■ Social skills and network building Group approaches <ul style="list-style-type: none"> ■ Social support ■ Socialization skill education ■ Gender-specific issues Marital and family approaches <ul style="list-style-type: none"> ■ Spouse counseling ■ Marital therapy ■ Family therapy Case management <ul style="list-style-type: none"> ■ Linkage to community social programs ■ Home visitation Individual counseling <ul style="list-style-type: none"> ■ Focus on psychodynamic issues in relationships |
| Promote health <ul style="list-style-type: none"> ■ Improve sleep habits ■ Improve nutrition ■ Increase exercise ■ Reduce tobacco use ■ Reduce stress | Medical <ul style="list-style-type: none"> ■ Provide primary medical care Cognitive-behavioral (group or individual) <ul style="list-style-type: none"> ■ Self-management skills training Group approaches <ul style="list-style-type: none"> ■ Health education ■ Education on nutrition, diet, cooking, shopping ■ Sleep hygiene |
| Stabilize and resolve comorbidities <ul style="list-style-type: none"> ■ Medical ■ Psychiatric (e.g., depression, anxiety) ■ Sensory deficits | Medical <ul style="list-style-type: none"> ■ Consultation and special assessments, including medication assessment ■ Primary and specialized medical care ■ Psychiatric care for chronic mental disorders (by geriatric psychiatrist, if possible) ■ Pain management for chronic pain disorders ■ Antidepressants, antianxiety medication Cognitive-behavioral (group or individual) <ul style="list-style-type: none"> ■ Relaxation training ■ Depression |

Case Management, Community-Linked Services, and Outreach

Case management is the coordination and monitoring of the varied social, health, and welfare services needed to support an older adult's treatment and recovery. One person, preferably a social worker or nurse, should link all staff who play a role in the client's treatment as well as key family members and other important individuals in the client's social network.

Case managers must have strong linkages through both formal and informal arrangements with community agencies and services such as

- Medical practitioners, particularly mental health providers, geriatricians, and geriatric counselors
- Medical facilities for detoxification and other services
- Home health agencies
- Housing services for specialized housing (i.e., wheelchair-accessible housing, congregate living)
- Public and private social services providing in-home support for housekeeping, meals, etc.
- Faith community (e.g., churches, synagogues, mosques, temples)
- Transportation services
- Senior citizen centers and other social activities
- Vocational training and senior employment programs
- Community organizations that place clients in volunteer work
- Legal and financial services
- The Area Agency on Aging (funded under Title 20)

Other Adjunctive Approaches

A number of other treatment approaches, used in conjunction with the major approaches already discussed, are useful in responding to older substance abusers.

Substance abuse treatment providers are moving toward a greater recognition of the role of spirituality in recovery, and providers should not hesitate to build on the religious belief systems of older clients, when appropriate. One caution: Older adults who have never subscribed to a religious belief system may not be ideal candidates for spiritually oriented therapy or referral to 12-Step fellowship programs.

Programs that specialize in the treatment of a particular ethnic or racial group may adopt strategies specific to that group (e.g., the use of

tribal rituals in the treatment of Native American substance abusers). A variety of nontraditional methods for tension reduction (e.g., therapeutic massage, meditation, acupuncture) have been suggested as applicable to older adults, although these methods remain largely untested.

Discharge Plans and Aftercare

As part of the discharge process, a counselor or case manager also develops an aftercare program with the client.

Standard features of most discharge plans for older adults include

- Age-appropriate Alcoholics Anonymous, Pills Anonymous, Rational Recovery, women's or other support groups
- Ancillary services needed to maintain independence in the community
- Ongoing medical monitoring
- Involvement of an appropriate case manager if needed to advocate for the client and ensure needed services are provided

In addition, for older adults, this may entail arranging transportation to followup appointments and reminders to note dates and times on the calendar, as well as fulfilling more traditional functions like monitoring progress to prevent or reduce the negative impact of relapse.

Some communities have established, integrated social service networks that enable clients to receive coordinated care. However, stand-alone programs in communities without defined networks may have to initiate linkages with other services themselves. Some treatment programs have begun this process of network building by publicizing their services to other local agencies and health care facilities. Prior consultation with the local Office on Aging and other resources in the community that target older adults helps to ensure that the resulting network is responsive to their special needs. In rural areas, treatment programs serving older adults face additional challenges. In these settings, collaboration among health and social service programs is crucial to resolve problems posed by geography, lack of public transportation, sparse and distant services, and social isolation. CSAT's Technical Assistance Publications *Rural Issues in Alcohol and Other Drug Abuse Treatment* (CSAT, 1996), *Treating Alcohol and Other Drug Abusers in Rural and Frontier Areas* (CSAT, 1995), and *Bringing Excellence to Substance Abuse Services in Rural and Frontier America* (CSAT, 1997) have more information on surmounting these barriers.

Specialized Treatment Issues for Prescription Drug Abuse

Because so many problems with prescription drug abuse stem from unintentional misuse, approaches for responding to these clients differ in some important respects from treatment for alcohol abuse and dependence. Issues that need to be addressed include

- Educating and assisting patients who misuse prescribed medications to comply consistently with dosing instructions
- Providing informal or brief counseling for patients who are abusing a prescribed substance with deleterious consequences
- Engaging drug-dependent patients in the formal treatment system at the appropriate level of care
- Understanding how practitioners' prescribing behavior contributes to the problem so they can address it both with clients and uninformed health care practitioners in the community

Misuse by the Patient

In general, the causes of noncompliance with a prescribed medication regimen can be categorized as

- A lack of judgment or misconceptions about the drugs
- An inability to manage the medication regimen, either because it is complex or the patient has persistent memory problems and will need regular supervision
- Insufficient resources for purchasing or storing the medications
- Intentional misuse to obtain results other than for those prescribed (e.g., pain pills to sleep, relax, soften negative affect)

Unless patient interventions address the real reasons for noncompliance, they are not likely to be effective. For example, if a 73-year-old woman is skipping doses of her blood pressure medication, the provider needs to learn whether this happens because (1) the patient only takes the medicine when she feels ill rather than on the prescribed schedule, (2) the medicine sometimes makes her feel unpleasantly dizzy, (3) the patient frequently forgets whether she took the medicine, or (4) the patient cannot afford the drug and tries to do without from time to time so that she will have a supply available when she feels she needs it.

In general, medication noncompliance takes the following forms:

- Omitting doses or changing the frequency or timing of doses
- Doubling up on the dosage after forgetting to take the previous dose
- Taking the entire day's medications in the morning for fear of forgetting to take all the doses of all the medications as prescribed
- Increasing doses or dosing frequency
- Taking the wrong drugs
- Borrowing or sharing drugs
- Supplementing prescribed drugs with other over-the-counter medications or "leftover" medicines from an earlier illness
- Continuing to use alcohol or other contraindicated drugs or foods while taking the prescribed medicines
- Engaging in contraindicated activities while taking the medications (e.g., driving motor vehicles, spending time in the sun)
- Failing to tell the prescribing physician about all the other medications (prescribed and over-the-counter) being used or to report significant or unexpected side effects or adverse reactions
- Storing medications improperly (not refrigerating those that require a continued cold temperature) or using prescriptions with expired expiration dates.

Misuse (Misprescribing) by the Health Care Provider

Health care professionals need to keep abreast of current information about appropriate prescribing practices for older patients as well as new drugs with less hazardous profiles. Health care professionals also need to be reminded of ways to convey information that are easily understood and used by older patients (e.g., written as well as spoken, disseminated to family caregivers and advocates as well as the patient).

Credentials and Training for Program Staff

Staff working with older adults need to understand the developmental tasks of aging and the basic principles of educational gerontology—how older adults learn and process material. For this reason, Panel members believe that any program that treats even a few older adults should have at least one staff person who is trained in the specialization of gerontology within his or her discipline.

Programs with linkages to layers of services—large addictions programs or programs linked to hospitals, health care systems, or multiservice agencies—are common in urban settings. The following professionals should ideally be available to a treatment program, whether as members of the program's treatment teams or as resources available through the program's linkages with other services:

- A geriatrician
- A geriatric psychiatrist
- A geropsychologist
- A gerontological counselor
- A nutritionist
- An activities director or recreational therapist (to make home visits, increase socialization, teach activities to fill leisure time)
- A chaplain or other member of the clergy
- Occupational therapists
- Social workers (clinical, community, administrative)
- Peer counselors (particularly valuable because they have many life experiences in common with clients)

Facilities should project the attitude that they want to serve older adults. When centers offer age-

specific programs with staff experienced in aging issues and interested in working with older adults, use by older adults increases (Fleming et al., 1984; Lebowitz, 1988; Lebowitz et al., 1987; Light et al., 1986). Similarly, in the treatment of alcohol abuse, research suggests that age-specific programs may be more attractive and effective (Atkinson, 1995; Kofoed et al., 1987).

Characteristics of staff who work with older clients should include people who

- Actually like adults of this age group
- Have a sense of the issues involved in aging
- Are willing to listen and to be patient with the older adult's pace of movement and speech
- Possess a sense of humor
- Have nonconfrontational personalities
- Are able to work in groups as trainers or teachers
- Have ability to be flexible and are willing to carry out tasks that may not be considered "professional"

Effective treatment for the older adult is more holistic, more supportive, and often a great deal more complicated than standard addiction treatment.

Chapter 6

Outcomes and Cost Issues in Alcohol Treatment for Older Adults

Outcomes research is concerned not only with results of studies but also with determining what exactly should be studied. For alcohol treatment among older adults, for example, should the measure of success be treatment compliance? Amount of alcohol consumed? Level of physical health? Psychological well-being? Payers increasingly are reimbursing only treatment approaches that have been validated by outcome studies—in particular, studies that quantify resource savings.

Measurement of Multidimensional Outcomes for Older Adults

Consumption levels are not the only measure of success: Drinking patterns, alcohol-related problems, physical and emotional health functioning, and quality of life can also be used to assess alcohol intervention and treatment outcomes with populations of older adults. It is particularly important to use benchmarked methods to assess older adults to determine whether treatment regimens are effective. Older adults have unique issues based on changes in physical functioning, changes in tolerance to alcohol, and internal (e.g., hearing, eyesight) and external (e.g., death of spouse, retirement) losses requiring a multidimensional approach to assessment and outcome evaluation to ameliorate potential reasons for relapse or a return to hazardous drinking.

Outcome assessment is invaluable from both a management and a referral perspective. The providers of treatment, the clinicians and agencies referring patients, and patients themselves need to have information regarding the likely outcomes of treatment. Because treatment options range from brief interventions to structured outpatient and inpatient treatment programs, evaluation is recommended at varying points in the treatment process (McLellan and Durell, 1996). Initial evaluation in

any setting should take place at the beginning of the intervention or treatment to obtain baseline data. McLellan and Durell recommend conducting first followup evaluations 2 weeks to 1 month after the patient leaves the inpatient setting. The short timeframe reflects the need to determine if the patient is engaged in aftercare with an outpatient program to maximize the effect of inpatient treatment.

For the purposes of this section, outcome measurement will include methods to measure alcohol use and alcohol-related problems, physical and emotional health functioning, and quality of life and well-being.

Measures of Alcohol Use

Drinking patterns can be assessed using approximations such as average number of drinking days per week and average number of drinks per occasion or day. Two of the instruments assessing average consumption are the Alcohol Use Disorders Identification Test (AUDIT) (Babor et al., 1992) and the Health Screening Survey (HSS) (Fleming and Barry, 1991), both of which are reproduced in Appendix A.

The HSS, originally developed by Wallace and Haines and adapted by Fleming and Barry, measures average quantity and frequency of alcohol use in the previous 3 months (Wallace and Haines, 1985; Fleming and Barry, 1991) and includes parallel questions about weight, exercise, and smoking. It has been used with older adults as part of a brief intervention trial (Fleming et al., 1997a).

The most accurate method used to assess current alcohol consumption is the Time Line Follow Back (TLFB) procedure. TLFB is a structured interview that uses calendar cues (e.g., holidays, family events, trips) to quantify daily alcohol use over a period ranging from 7 days to a number of months (Sobell et al., 1988, 1996). This method has shown high test-retest reliability in a variety of drinking populations ranging from normal drinkers to heavy drinkers to persons participating in inpatient or outpatient treatment.

Measures of Alcohol Problems

The use of multidimensional screening and outcome instruments provides clinicians, programs, and referral agencies with measurements regarding the nature and severity of problems presented by persons who abuse alcohol.

An important multidimensional screening instrument for use specifically with older adults is the Michigan Alcoholism Screening Test—Geriatric version (MAST-G) (Blow et al., 1992), reproduced in Chapter 4. This tool was developed because many of the screening measures did not identify alcoholism among older adults as reliably as among younger populations.

The Addiction Severity Index (ASI) (McLellan et al., 1985, 1990) was developed specifically to assess over time the alcohol-related problems and the severity of symptoms of patients in treatment for alcohol and drug abuse and dependence. The ASI is a semistructured interview that provides information about aspects of the patient's life that may contribute to the substance abuse syndrome.

The focus of the interview is on seven functional areas that have been shown to be affected by substance abuse:

- Medical status
- Employment and support
- Drug use
- Alcohol use
- Legal status
- Family and social status
- Psychiatric status

The ASI is targeted to all adult populations in substance abuse treatment or in treatment for co-occurring psychiatric and substance abuse disorders. It is included in this review because it is a standard measure in the field and can provide important information regarding older adults in treatment settings, particularly in areas of greatest concern with this population—medical status, alcohol use, family and social status, and psychiatric status.

Measures of Physical and Emotional Health

One of the most widely used measures of physical and emotional health is the Medical Outcomes Study 36-Item Short Form Health Survey (SF-36). When used for outcome measurement, these measures are often administered at intake, during treatment, at discharge, and at followup intervals (Smith, 1996).

Measures of Quality of Life

Quality of life measures have most frequently been used for outcomes assessment in mental health treatment. One of the most widely used instruments is the Quality of Life Interview (QLI) (Lehman, 1988). Research suggests that quality of life, as perceived by the patient, is an important factor in maintaining optimal functioning.

Salient factors in functioning and relapse for older adults include

- Housing
- Leisure
- Family
- Social relationships
- Health
- Safety
- Finances

Costs of Alcohol Treatment

Outcomes studies obviously can help treatment providers and health care professionals improve treatment. They also play an important role in paying for treatment: Third-party payers want validated proof that the treatment approaches they are reimbursing actually work. The other side of this equation is the cost—to individuals, the health care system, and society at large—of alcohol-related problems. If costs of treatment can be measured against these larger costs, it is more likely that treatment will be reimbursed.

Special Issues

As the number of older adults rises, the use of mood-altering drugs such as alcohol and tranquilizers by older adults is a growing area of concern from a clinical and research perspective. As the Baby Boom generation reaches traditional retirement age, the field of substance abuse treatment and research will be faced with both growing numbers of individuals who have alcohol-related problems and emerging problems unique to the aging population, namely a potential increased prevalence of illicit drug use and drug-related problems.

There are some *special issues* related to older adult substance abuse that have been the target of clinical concern and some initial research, which needs to be expanded in order to address the needs of the current and future cohorts of older adults:

- Elder abuse and neglect
- Homelessness
- Underrepresentation of older adults in treatment settings

Researchers in gerontology, substance abuse treatment, and related fields must take the lead in

providing the above information. Only with such knowledge can clinicians and policymakers improve the identification of substance use disorders among older adults. Without the information—and the response—such disorders will take a greater and greater toll on one of the most vulnerable and fastest growing sectors of the population.

Chapter 7

Legal and Ethical Issues

*Adapted from a chapter by Margaret K. Brooks, Esq.**

Screening any population for substance abuse raises key legal and ethical concerns: how one can inquire about an individual's alcohol and drug use while continuing to respect that person's autonomy and privacy. Screening of older adults for substance abuse brings these concerns into particularly sharp focus—whether the person screening is a clinician, a staff member at a senior center, a member of the clergy, an adult protective service worker, a Meals-On-Wheels volunteer, a pharmacist, a community health worker, an adult day care worker, or staff member at a long-term care facility.

This chapter examines how the issues of autonomy and privacy (or confidentiality) affect the way providers working with older adults may screen for substance use problems. The first section discusses the relationship between patient or client autonomy and the provider's obligation to inform and counsel the older individual about the health risks of alcohol or other drug use. The second section concerns privacy of information about substance use problems: How can a provider keep accurate records and communicate with others concerned about the older individual's welfare without disclosing information that may subject the individual to scorn or create problems with family or third-party payers?

Autonomy and the Provider's Mission: A Dilemma

Americans attach extraordinary importance to being left alone. We pride ourselves on having perfected a social and political system that limits how far the government—and others—can control what we do. The principle of autonomy is enshrined in our Constitution, and our courts have

repeatedly confirmed our right to make our own decisions for ourselves.

Most of us cherish our autonomy and fear its loss, particularly as we age. Although providers who screen or assess for substance abuse do so because they are genuinely concerned about an individual's health or functioning, screening means seeking very personal information—an unavoidable intrusion on a person's autonomy and privacy. Alert to suggestions that their judgment or abilities are impaired, older adults may not always see a provider's effort to "help" as benign.

Performed insensitively, screening or assessment may intensify denial. A person of any age who is "in denial" may not realize, or want to realize, that he has to cut back on or give up his intake of alcohol or prescription medications; an older person may view the provider's questions and suggestions as intrusive, threatening, and offensive. Suggestions that an older individual's complaint has an emotional basis may tap an underlying reluctance to acknowledge an emotional component to any problem and reinforce the individual's resistance. Because the substance abuse label carries a powerful stigma, an older individual may become alarmed if a provider intimates that alcohol or drug abuse may be involved. It will be tempting for the older individual to point to the "normal" infirmities of old age as the source of his difficulty rather than acknowledge a problem with alcohol or other drugs.

How can the provider raise the question of alcohol and drug use constructively, without eliciting a defensive response? Should she raise the issue and then drop it at the slightest hint of resistance on the part of the older individual? Or should she intervene more forcefully—with argument or by involving the family?

To fulfill her ethical responsibility, the provider should do more than simply raise the issue. As the Consensus Panel suggests, most older adults are unaware that their metabolism of alcohol and pre-

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scription drugs changes as they age and that lower amounts of alcohol and medicines may incapacitate them. Respect for a person's autonomy means informing him of all relevant medical facts and engaging him in a discussion about his alternatives. If there is a substance abuse problem, the provider can supply the information and encouragement, but only the person with the problem has the power to change what he is doing. Respecting the patient's autonomy—his right to make choices—is central to encouraging that change.

Privacy and Confidentiality

Aside from perceived threats to autonomy, an older person may also be concerned about the practical consequences of admitting a substance use problem. Such patients may find it difficult or impossible to obtain coverage for hospitalization costs if an insurer or health maintenance organization (HMO) learns that their traumatic injuries were related to alcoholism. Relationships with a spouse, children, grandchildren, or friends may suffer. Adverse consequences such as these may discourage patients with substance use problems from seeking treatment.

Concern about privacy and confidentiality is fueled by the widespread perception that people with substance use disorders are weak and/or morally impaired. For an older person, this concern may well be compounded by an apprehension that others may view acknowledgment of a substance use disorder as a sign of inability to continue living independently. If the individual is having family problems—with a spouse or with children—information about substance use could have an adverse impact on resolution of those problems. Or the individual may experience difficulties with health insurance.

Federal Law

The concern about the adverse effects that social stigma and discrimination have on patients in recovery (and how those adverse effects might deter people from entering treatment) led the Congress to pass legislation and the U.S. Department of Health and Human Services to issue a set of regulations to protect information about individuals' substance abuse. The law is codified at 42 U.S.C. § 290dd-2. The implementing Federal regulations, "Confidentiality of Alcohol and Drug Abuse Patient Records," are contained in 42 CFR Part 2 (Vol. 42 of the Code of Federal Regulations, Part 2).

In most settings where older adults receive care or services, Federal confidentiality laws and regu-

lations do not apply.¹ Providers should be aware, however, that if a health care practice or social service organization includes someone whose primary function is to provide substance abuse assessment or treatment and if the practice or organization benefits from "Federal assistance,"² that practice or organization must comply with the Federal law and regulations and implement special rules for handling information about patients who may have substance abuse problems.³

Moreover, the fact that most providers for older adults are not subject to the Federal rules does not mean that they can handle information about their clients' substance use problems in a cavalier manner. Because of the potential for damage, providers should always handle such information with great care.

State Law

Although Federal rules do not restrict how most providers gather and handle information about an older individual's substance abuse, there are other rules that may limit how such information may be handled. State laws offer some protection to medical and mental health information about patients and clients. Most doctors, social service workers, and clients think of these laws as the "doctor-patient privilege" or "social worker-client privilege" or "psychotherapist-patient privilege."

Strictly speaking, these privileges are rules of evidence that govern whether a professional provider can be asked or compelled to testify in a court case about a patient or client. In many States, however, laws offer wider protection. Some States have special confidentiality laws that explicitly prohibit physicians, social workers, psychologists, and others from divulging information about patients or clients without consent. States often include such prohibitions in professional licensing laws; such laws generally prohibit licensed professionals from divulging information about patients or clients, and they make unauthorized disclosures grounds for disciplinary action, including license revocation.

Each State has its own set of rules, which means that the scope of protection offered by State law varies widely.

Whether a communication is "privileged" or "protected" may depend on a number of factors:

- The type of professional provider holding the information and whether he or she is licensed or certified by the State
- The context in which the information was communicated

- The context in which the information will be or was disclosed
- Exceptions to any general rule protecting information
- How the protection is enforced

Professionals covered by the “doctor-patient” or “therapist-client” privilege

Which professions and which practitioners within each profession are covered depends on the State where the professional practices.

Depending on their professional training (and licensing), primary care physicians, physician assistants, nurse-practitioners, nurses, psychologists, social workers, and others may be covered by State prohibitions on divulging information about patients or clients. Note that even within a single State, the kind of protection afforded information may vary from profession to profession. Professional providers should learn whether any confidentiality law in the State where they practice applies to their profession.

The context in which the information was communicated

State laws vary tremendously in this area, too. Some States protect only the information that a patient or client communicates to a professional in private, in the course of the medical or mental health consultation. Information disclosed to a clinician in the presence of a third party (like a spouse) is not protected.

Understanding what medical information is protected requires professional providers to know whether State law recognizes the confidentiality of information in the many contexts in which the professional acquires it.

Circumstances in which “confidential” information is protected from disclosure

Some States protect medical or mental health information only when that information is sought in a court proceeding. If a professional divulges information about a patient or client in any other setting, the law in those States will not recognize that there has been a violation of the individual's right to privacy. Other States protect information in many different contexts and may discipline professionals who violate their patients' privacy, allow patients to sue them for damages, or criminalize behavior that violates patients' privacy. The diversity of State rules in this area compounds the difficulty profes-

sionals face in becoming knowledgeable about what rules apply to them.

Exceptions to State laws protecting medical and mental health information

Consent

All States permit health, mental health, and social service professionals to disclose information if the patient or client consents. However, each State has different requirements regarding consent.

Other exceptions

Consent is not the only exception. All States also require the reporting of certain infectious diseases to public health authorities and some require the reporting of elder abuse to protective service agencies, although definitions of “infectious disease” and “elder abuse” vary. And most States require health care professionals and mental health counselors to report to the authorities threats patients make to inflict harm on others. There are States that permit or require health care professionals to share information about patients with other health care professionals without the patients' consent, but some limit the range of disclosure for certain diseases, like HIV. Most States make some provision for communicating information to health insurance or managed care companies.

Many of the situations that physicians and social service workers face daily—processing health claims or public benefit applications, for example—are covered by one of these exceptions. To fully understand the “rules” regarding privacy of medical and mental health information, professionals must also know about the exceptions to those rules. Those exceptions are generally in the statute books—in either the sections on evidence or the professional licensing sections, or both. The state licensing authority as well as professional associations can usually help answer questions about State rules and the exceptions to those rules.

Enforcing confidentiality protections

The role of the courts

To determine the “law”—that is, the rule one must follow—in any particular area, an attorney will search for statutes, regulations, administrative rulings, and court decisions. There is no question that in this country, the courts play a large role in “making” law—particularly in an area like privacy, which involves human behavior, shades of meaning, and intent. No legislator drafting a statute (or bureaucrat drafting a regulation) can foresee all the circumstances under which it may be applied.

When one party sues another, a court is forced to decide whether a provider's disclosure of medical information was appropriate or whether such information should be disclosed during the lawsuit itself.

Penalties for violations

States differ in the ways they discipline professionals for violations of patients' or clients' privacy. In some States, violation of confidentiality is a misdemeanor, punishable by a fine or short jail term. In many States, the professional licensing agency has the power to bring disciplinary charges against a professional who violates a client's privacy. Such charges may result in censure or license suspension or revocation. Finally, the State may permit the aggrieved patient or client to sue the professional for damages caused by the violation of his right to confidentiality.

The reality is, these enforcement mechanisms are rarely used. States rarely prosecute privacy violation offenses and professional disciplinary committees in most States are more concerned with other kinds of professional infractions. That is not to say that violation of a patient's privacy is cost-free. A patient or client who thinks he has been hurt by a professional's indiscretion is free to sue; while such cases are difficult for clients to win, they can cause the professional and the organization employing her a good deal of grief—financial, emotional, and professional. Even short of litigation, no professional wants to acquire the reputation of being thoughtless or indiscreet.

Strategies for Dealing With Common Situations

Charting substance use information

One way for a professional to safeguard clients' privacy and avoid breaking the rules is to develop a charting, or record-keeping, system that is accurate but still protects clients' rights to privacy and confidentiality. It is important to remember how many people could see a client's medical, mental health, or social service record. A medical chart, for example, will be seen by the medical office staff, the insurance company (or HMO or managed care organization [MCO]), and in the event of a referral, another set of clinicians, nurses, clerical workers, and insurers. If the patient is involved in litigation and his medical or mental health is an issue, the court will most likely order disclosure of his chart or file in response to a subpoena.

When a provider documents the results of substance abuse screening or assessment or flags an issue to be raised the next time he sees the client, he

should use neutral notations or reminders that do not identify the problem as being substance-use-related. Following are three record-keeping systems that comply with the stringent Federal confidentiality regulations, protect clients' autonomy and privacy, and can be used in a wide variety of settings (TIP 16, *Alcohol- and Other-Drug Screening of Hospitalized Trauma Patients*, CSAT, 1995):

- The "minimalist" approach, which relies on the provider to enter only that information in the chart that is required for accuracy and to use neutral terms wherever possible.
- The "rubber band" approach, which segregates substance abuse information in a separate "confidential" section in the chart. Information in this section would be shared with other providers only on a need-to-know basis, without being open to the view of every staff person who picked up the chart.
- The "separate location" approach, which keeps sensitive information separate from the rest of the client's chart. The other place might be a locked cabinet or other similarly secure area. A "gatekeeper" familiar with the provider's record-keeping system and the reasons for the extra security would be responsible for deciding when others—within or outside the office—will have access to this information. This approach provides, in effect, a stronger "rubber band" than that described in the second approach.⁴

The push toward computerization of medical records will complicate the problem of keeping sensitive information in medical records private. Currently, there is protection afforded by the cumbersome and inefficient way many, if not most, medical, mental health, and social service records make their way from one provider to another. When records are stored in computers, retrieval can be far more efficient.

Communicating with others

One of the trickiest issues is whether and how providers of older adults health care should communicate with others about their clients' substance use problems. Communications with others concerned about the client may confirm the provider's judgment that the client has a substance use problem or may be useful in persuading a reluctant client that treatment is necessary.

Before a provider attempts to gather information from other sources or enlist help for a patient or client struggling with recovery, he should ask the older client's permission to do so. Speaking with relatives (including children), doctors, or other

health and mental health professionals not only intrudes on the client's autonomy, it also poses a risk to her right to privacy. Gathering information (or responding to questions about a client's problems) from a spouse, child, or other provider can involve an explicit or implicit disclosure that the provider believes the client or patient has a substance use problem. And the provider making such a disclosure may be inadvertently stepping on a land mine.

Making inquiries or answering questions behind the client's back may seriously jeopardize the trust that has developed between the provider and the client and undermine his attempt to offer help. The professional who talks to the client's son and then confronts her with their joint conclusions runs the risk that he will damage his relationship with the client. Feeling she can no longer trust the provider and angry that he has shown little respect for her autonomy or privacy, the client may refuse to participate in any further discussions about her problems.

Dealing with questions of incapacity

Most older clients or patients are fully capable of comprehending the information and weighing the alternatives offered by a provider and making and articulating decisions. A small percentage of older patients or clients are clearly incapable of participating in a decision-making process. In such cases, the older person may have signed a health care proxy or may have a court-appointed guardian to make decisions in his stead.

The real difficulty arises when a provider is screening or assessing an older person whose mental capacity lies between those two extremes. The client or patient may have fluctuating capacity, with "good days" and "bad days" or periods of greater or lesser alertness depending upon the time of day. His condition may be transient or deteriorating. His diminished capacity may affect some parts of his ability to comprehend information but not others.

How can the provider determine whether the patient or client understands the information she is presenting, appreciates the implication of each alternative, and is able to make a "rational" decision, based on his own best interests? There is no easy answer to this question. One can, however, suggest several approaches.

Maximizing autonomy. The provider can help the patient or client who appears to have diminished capacity through a gradual information-gathering and decision making process. Information the

client needs should be presented in a way that allows the patient or client to absorb it gradually. The provider should clarify and restate information as necessary and may find it helpful to summarize the issues already covered at regular intervals. Each alternative and its possible consequences should be laid out and examined separately. Finally, the provider can help the client identify his values and link those values to the alternatives presented. By helping the patient or client narrow his focus and proceed step-by-step, the provider may be able to assure herself that the client, despite his diminished capacity, has understood the decision to be made and acted in his own best interest.

Enlisting the help of a health or mental health professional. If working with the patient or client in a process of gradual information-gathering and decision-making is not making headway, the provider can suggest that together they consult a health or mental health professional. Perhaps there is someone who has known the patient or client for a number of years who has a grasp of the client's history and better understanding of the obstacles to decision-making. Or, the provider may suggest a specialist who can help determine why the patient is having difficulty and whether he has the capacity to make this kind of decision.

Enlisting the help of family or close friends. Another approach is for the provider to suggest to the patient or client that they call in a family member or close friend who can help them organize the information and sort through the alternatives. Asking the client who he thinks would be helpful may win his endorsement of this approach.

When the client cannot grasp the information or come to a decision. If the provider's efforts to inform the patient or client and help him reach a decision are unsuccessful, she might seek his permission to consult a family member or close friend to discuss the problem. If the client consents, the provider should lay out her concerns for the family member or friend. It may be that the client has already planned for the possibility of his incapacity and has signed a durable power of attorney or a health care proxy.

Guardianship. A guardian⁵ is a person appointed by a court to manage some or all aspects of another person's life. Anyone seeking appointment of a guardian must show the court (1) that an individual is disabled in some way by disease, illness, or senility, and (2) that the disability prevents him

from performing the tasks necessary to manage an area or areas of his life.

Each State handles guardianship proceedings differently, but some principles apply across the board: Guardianship is not an all-or-nothing state. Courts generally require that the person seeking appointment of a guardian prove the individual's incapacity in a variety of tasks or areas. Courts may apply different standards to different life tasks—managing money, managing a household, making health care decisions, entering contracts. A person may be found incompetent to make contracts and manage money but not to make his own health care decisions (or vice versa), and the guardianship will be limited accordingly.

Guardianship diminishes the older adult's autonomy and is an expensive process. It should, therefore, be considered only as a last resort.

Making referrals to substance abuse treatment programs

The provider has persuaded the patient or client to try outpatient treatment and knows the director of an excellent program in the immediate area. Rather than simply picking up the phone and letting the director know she has referred the patient, she should consult the patient about the specific treatment facility. Though it may seem that consent to treatment is the same as consent to referral to a particular facility, it takes very little time to get the patient's consent, demonstrates respect for the client or patient, and protects the provider if, say, the treatment program's director is a relative or has some other connection to the client.

Communications with insurers, HMOs, and other third-party payers

The structure of health, mental health, and ancillary social service care for older adults is changing rapidly. Of course, older adults are covered by Medicare, but many have supplementary insurance or have joined HMOs or are entitled to government-sponsored social services because of particular medical, physical, or mental disabilities. How should the professional provider communicate with these different types of entities?

Traditional health insurance programs offering reimbursement to patients for health care expenditures typically require patients to sign claim forms containing language consenting to the release of information about their care. The patient's signature authorizes the practitioner to release such information. Although HMOs do not require patients to submit claim forms, both practitioners

and patients understand that the HMO or MCO can review clinical records at any time and may well review records if it has questions about the patient's or client's care.

Should the provider rely on the patient's signed consent on the health insurance form or the HMO contract and release what she has in her chart (or a neutral version of that information)? Or should she consult the patient?

The better practice is for the provider to frankly discuss with the patient what information she intends to disclose, the alternatives open to the client (disclosure and refusal to disclose), and the likely consequences of those alternatives. Will the information the provider sends explicitly or implicitly reveal the nature of the patient's problem? Does the client's chart contain a substance abuse diagnosis? Once again, the provider confronts the question of how such information should be recorded. Has she balanced the need for accuracy with discretion and a respect for patients' privacy? Finally, even if the chart or file contains explicit information about the client's substance use problem, can the provider characterize the information and her diagnosis in more neutral terms when releasing information to the third-party payer?

Once the client understands what kind and amount of information the provider intends to send a third-party payer, he can decide whether to agree to the disclosure. The provider should explain that if she refuses to comply with the third-party payer's request for information, it is likely that at least some related services will not be covered. If the client expresses concern, she should not mislead him, but confirm that once a third-party payer learns he has had a substance use problem, he could and may lose either some of his insurance coverage or parts of other entitlements and be unable to obtain other coverage.⁶

The final decision should be the client's. He may well decide to pay out of pocket. Or he may agree to the limited disclosure and ask the provider to inform him if more information is requested.

As managed care becomes more prevalent throughout the country, medical and mental health providers are finding that third-party payers demand more and more information about patients and about the treatment provided to those patients in order to monitor care and contain costs. Providers need to be sensitive about the amount and kind of information they disclose because there is a risk that this information may be used to deny future benefits to the client. Chart notes may also contain detailed and very personal information about family life that may be unnecessary for a third-party payer to review

in order to determine whether and what kind of treatment should be covered.

As in so many other areas involving patients' privacy, it is best to follow two simple rules: First, keep notations and documentation as neutral as possible while maintaining professionally acceptable standards of accuracy. Second, consult the client and let the client decide whether to agree to the disclosure.

Communicating with the legal system

If a doctor, psychologist, social worker, or other provider gets a call from a lawyer asking about a patient or client, or a visit from a law enforcement officer asking to see records, or a subpoena to testify or produce medical records, what should he or she do? As in other matters of privacy and confidentiality, (1) consult the patient, (2) use common sense, and (3) as a last resort, consult State law (or a lawyer familiar with State law).

Responding to lawyers' inquiries. Say a lawyer calls and asks about Emma Bailey's medical, mental health, or social service history or treatment. As a first approach to the question, the provider could tell the lawyer, "I don't know that I have a client with that name. I'd have to check my records"⁷ or tell the caller that he must consult with his client before having a conversation about her: "I'm sure you understand that I am professionally obligated to speak with Emma Bailey before I speak with you." It will be hard for any lawyer to disagree with this statement.

The provider should then ask the client if she knows what information the caller is seeking and whether the client wants him to disclose that or any other information. He should leave the conversation with a clear understanding of the client's instructions—whether he should disclose the information, and if so, how much and what kind. It may be that the lawyer is representing the client in a case and the client wants the provider to share all the information he has. On the other hand, the lawyer may represent someone with whom the client has a dispute. There is nothing wrong with refusing to answer a lawyer's questions.⁸

If the lawyer represents the client and the client asks the provider to share all information, the provider can speak freely with the lawyer. However, if the provider is answering the questions of a lawyer who does not represent the client (but the client has consented to the disclosure of *some* information), the provider should listen carefully to

each question, choose his words with care, limit each answer to the question asked, and take care not to volunteer information not called for.

Visits by law enforcement. A police officer, detective, or probation officer who asks a provider to disclose medical, mental health, or social service information about a client or a client's case records can usually be handled in a similar manner.⁹ The provider can safely tell the officer, as he might a lawyer, "I'm sure you understand that I am professionally obligated to speak with my patient before I speak to you."¹⁰

The provider should then speak with the client to find out whether she knows the subject of the officer's inquiry, whether she wants the provider to disclose information and if so, how much and what kind. The caretaker might end the conversation by asking whether there are any particular areas the client would prefer he not discuss with the officer.

When a law enforcement officer comes armed with a search warrant, the answer is different. In this case, the provider has no choice but to hand over the records listed in the warrant.

Responding to subpoenas. Subpoenas come in two varieties. One is an order requiring a person to testify, either at a deposition out of court or at a trial. The other—known as a subpoena duces tecum—requires a person to appear with the records listed in the subpoena. Depending on the State, a subpoena can be signed by a lawyer or a judge. Unfortunately, it cannot be ignored.

In this instance, the provider's first step should be to call Emma Bailey—the client about whom he is asked to testify or whose records are sought—and ask what the subpoena is about. It may be that the subpoena has been issued by or on behalf of Emma's lawyer, with Emma's consent. However, it is equally possible that the subpoena has been issued by or on behalf of the lawyer for an adverse party. If that is the case, the provider's best option is to consult with Emma's lawyer to find out whether the lawyer will object—ask the court to "quash" the subpoena—or whether the provider should simply get the client's consent to testify or turn over her records.¹¹ An objection can be based on a number of grounds and can be raised by any party as well as by the person whose medical information is sought. If the provider is covered by a State statutory privilege, he may be able to assert the client's privilege for her.

Conclusion

It is essential for those who work with older adults to respect their clients' autonomy and rights to privacy and confidentiality if they are to be effective in screening and assessing clients for substance use disorders and persuading them to cut down their use or enter treatment. In most situations, providers can follow these simple rules: (1) consult the client, (2) let the client decide, and (3) be sensitive to how information is recorded or disclosed. It is only as a last resort that the provider will have to consult State law or a lawyer.

Endnotes

¹ For many years, there was confusion about whether general medical care settings such as primary care clinics or hospital emergency rooms were subject to the Federal law and regulations because they provided substance abuse diagnosis, referral, and treatment as part of their services. In 1995, DHHS revised the definition of the kinds of "programs" subject to the regulations that made it clear that the regulations do not generally apply to a general medical care facility unless that facility (or person) holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment, or referral for treatment . . . (42 CFR § 2.11).

The full text of § 2.11 now reads:

Program means:

- (a) An individual or entity (other than a general medical care facility) who holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment, or referral for treatment; or
- (b) An identified unit within a general medical facility which holds itself out as providing and provides, alcohol or drug abuse diagnosis, treatment, or referral for treatment; or
- (c) Medical personnel or other staff in a general medical care facility whose primary function is the provision of alcohol or drug abuse diagnosis, treatment, or referral for treatment and who are identified as such providers. (See § 2.12(e)(1) for examples.)

60 Federal Register 22,297 (May 5, 1995).

² The regulations provide that "federally assisted" programs include:

- Programs run directly by or under contract for the Federal government;
- Programs carried out under a Federal license, certification, registration, or other authorization, including certification under the Medicare Program, authorization to conduct a methadone maintenance treatment program, or registration to dispense a drug that is regulated by the Controlled Substances Act to treat alcohol or drug abuse;
- Programs supported by any Federal department or agency of the United States, even when the federal support does not directly pay for the alcohol or drug abuse diagnosis, treatment, or referral activities;
- Programs conducted by State or local government units that are supported by Federal funding that could be (but is not necessarily) spent for the substance abuse treatment program;
- Tax-exempt programs.

42 C.F.R. § 2.12(b).

³ For a full explanation of the Federal law and regulations, see TIP 8, Intensive Outpatient Treatment for Alcohol and Other Drug Abuse (CSAT, 1994) and TAP 13, Confidentiality of Patient Records for Alcohol and Other Drug Treatment (CSAT, 1994).

⁴ The Consensus Panel for TIP 16 noted: "Physical separation of clinical information is not unusual. Patient charts from past years are generally kept in a separate location. Physicians routinely request charts to be sent to them from this location so that they can review historical clinical information about the patient. In addition, nurses are quite accustomed to keeping some medications locked up and accessible only to designated personnel." (TIP 16, CSAT, 1995, p. 76)

⁵ In some States, a guardian is referred to as a fiduciary, conservator, or committee. The person who has a guardian is generally called a "ward" or an "incapacitated person."

- ⁶ Some States prohibit insurance companies from discriminating against individuals who have received substance abuse treatment; however, these kinds of discriminatory practices continue. Insurance companies routinely share information about applicants for life and disability insurance through the Medical Information Bureau—a data bank maintained by a private organization and supported by the industry.
- ⁷ In fact, in some States, depending on the provider's profession, the identity of patients or clients as well as their records are protected. Therefore, professionals should find out whether disclosing a patient's name or acknowledging that the individual about whom the lawyer is inquiring is a client would be considered a violation of the client's right to confidentiality.
- ⁸ A firm, but polite, tone is best. If confronted by what could be characterized as "stonewalling," a lawyer may be tempted to subpoena the information he is asking for, and more. The clinician will not want to provoke the lawyer into taking action that will harm the patient.
- ⁹ The only exception to this advice would be if the provider knew the patient was a fugitive being sought by law enforcement. In that case, in some States, a refusal to assist or give officers information might be a criminal offense.
- ¹⁰ As noted above, in those States where the identity of clients or patients as well as their medical or mental health records are protected, the professional should give a noncommittal response, such as "I'll have to check my records to see whether I have such a patient."
- ¹¹ In most instances, the provider is not legally required to notify the client or get his consent to release records that have been subpoenaed. However, notifying the client shows respect for his autonomy and privacy and gives him an opportunity to object to the subpoena.

Appendix A

Assessment and Evaluation Instruments

Appendix A contains the following items:

- The Alcohol Use Disorders Identification Test (AUDIT)
- Index of Activities of Daily Living (ADLs)
- Instrumental Activities of Daily Living (IADL) Scale
- Geriatric Depression Scale (GDS) Short Form
- The Center for Epidemiologic Studies Depression Scale (CES-D)
- Health Screening Survey (HSS), Revised

The Alcohol Use Disorders Identification Test (AUDIT)

The following guidelines, questions, and scoring instructions are excerpted from Babor, T.F.; de la Fuente, J.R.; Saunders, J.; and Grant, M. AUDIT: The Alcohol Use Disorders Identification Test: Guidelines for Use in Primary Health Care. Geneva, Switzerland: World Health Organization, 1992.

How To Use AUDIT

Screening with AUDIT can be conducted in a variety of primary care settings by persons who have different kinds of training and professional backgrounds. The core AUDIT is designed to be used as a brief structured interview or self-report survey that can easily be incorporated into a general health interview, lifestyle questionnaire, or medical history. When presented in this context by a concerned and interested interviewer, few patients will be offended by the questions. The experience of the WHO collaborating investigators (Saunders and Aasland, 1987) indicated that AUDIT questions were answered accurately regardless of cultural background, age, or gender. In fact, many patients who drank heavily were pleased to find that a health worker was interested in their use of alcohol and the problems associated with it.

In some patients, the AUDIT questions may not be answered accurately because they refer specifically to alcohol use and problems. Some patients may be reluctant to confront their alcohol use or to admit that it is causing them harm. Individuals who feel threatened by revealing this information to a health worker, who are intoxicated at the time of the interview, or who have certain kinds of mental impairment may give inaccurate responses. Patients tend to answer most accurately when

- The interviewer is friendly and nonthreatening
- The purpose of the questions is clearly related to a diagnosis of their health status
- The patient is alcohol- and drug-free at the time of the screening
- The information is considered confidential
- The questions are easy to understand

Health workers should try to establish these conditions before AUDIT is given. When these conditions are not present, the Clinical Screening Instrument following the AUDIT questionnaire may be more useful. Alternatively, health workers may also use AUDIT to guide an interview with a concerned friend, spouse, or family member. In some settings (such as waiting rooms), AUDIT may be administered as a self-report questionnaire, with instructions for the patient to discuss the meaning of the results with the primary care worker. In addition to these general considerations, the following interviewing techniques should be used:

- Try to interview patients under the best possible circumstances. For patients requiring emergency treatment or who are severely impaired, it is best to wait until their condition has stabilized and they have become accustomed to the health setting where the interview is to take place.
- Look for signs of alcohol or drug intoxication. Patients who have alcohol on their breath or who appear intoxicated may be unreliable respondents. Consider conducting the interview at a later time. If this is not possible, make note of these findings on the patient's record.
- If AUDIT is embedded, as recommended, in a longer health interview, then a transitional statement will be needed when the AUDIT questions are asked. The best way to introduce the AUDIT questions is to give the patient a general idea of the content of the questions, the purpose for asking them, and the need for accurate answers. The following is an illustrative introduction: "Now I am going to ask you some questions about your use of alcoholic beverages during the past year. Because alcohol use can affect many areas of health (and may interfere with certain medications), it is important for us to know how much you usually drink and whether you have experienced any problems with your drinking. Please try to be as honest and as accurate as you can be." This statement should be followed by a description of the types of alcoholic beverages typically consumed in the population to which the patient belongs (e.g., "By alcoholic beverages we mean your use of wine, beer, vodka, sherry, and so on."). If necessary, include a description of beverages that may not be considered alcoholic (e.g., cider, low alcohol beer).

- It is important to read the questions as written and in the order indicated. By following the exact wording, better comparability will be obtained between your results and those obtained by other interviewers.
- Most of the questions in AUDIT are phrased in terms of "how often" symptoms occur. It is useful to offer the patient several examples of the response categories (for example, "Never," "Several times a month," "Daily") to suggest how he might answer. When he has responded, it is useful to probe during the initial questions to be sure that the patient has selected the most accurate response (for example, "You say you drink several times a week. Is this just on weekends or do you drink more or less every day?"). If responses are ambiguous or evasive, continue asking for clarification by repeating the question and the response options, asking the patient to choose the best one. At times, answers are difficult to record because the patient may not drink on a regular basis. For example, if the patient was drinking intensively for the month prior to an accident, but not before or since, then it will be difficult to characterize the "typical" drinking sought by the question. In these cases it is best to record the amount of drinking and related symptoms for the heaviest drinking period of the past year, making note of the fact that this may be atypical or transitory for that individual.

Record answers carefully, using the comments section of the interview brochure to explain any special circumstances, additional information, or clinical inferences. Often patients will provide the interviewer with useful comments about their drinking that can be valuable in the interpretation of the total AUDIT score.

The AUDIT Questionnaire

Circle the number that comes closest to the patient's answer.

1. How often do you have a drink containing alcohol?

- (0) Never (1) Monthly or less (2) Two to four times a month (3) Two to three times a week (4) Four or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking? [Code number of standard drinks.]

- (0) 1 or 2 (1) 3 or 4 (2) 5 or 6 (3) 7 to 9 (4) 10 or more

3. How often do you have six or more drinks on one occasion?

- (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

4. How often during the last year have you found that you were not able to stop drinking once you had started?

- (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

5. How often during the last year have you failed to do what was normally expected from you because of drinking?

- (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

- (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

7. How often during the last year have you had a feeling of guilt or remorse after drinking?

- (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

- (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?

- (0) No (2) Yes, but not in the last year (4) Yes, during the last year

10. Has a relative or friend or a doctor or other health worker been concerned about your drinking or suggested you cut down?

(0) No

(2) Yes, but not in the last year

(4) Yes, during the last year

¹ In determining the response categories it has been assumed that one *drink* contains 10 g alcohol. In countries where the alcohol content of a standard drink differs by more than 25 percent from 10 g, the response category should be modified accordingly.

Record sum of individual item scores here. _____

Procedure for Scoring AUDIT

Questions 1–8 are scored 0, 1, 2, 3, or 4. Questions 9 and 10 are scored 0, 2, or 4 only. The response is as follows:

| | 0 | 1 | 2 | 3 | 4 |
|-----------------------|--------|-------------------|-------------------------------|-----------------------------|-----------------------------|
| Question 1 | Never | Monthly or less | Two to four times per month | Two to three times per week | Four or more times per week |
| Question 2 | 1 or 2 | 3 or 4 | 5 or 6 | 7 to 9 | 10 or more |
| Questions 3–8 | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| Questions 9–10 | No | | Yes, but not in the last year | | Yes, during the last year |

The minimum score (for nondrinkers) is 0 and the maximum possible score is 40. A score of 8 or more indicates a strong likelihood of hazardous or harmful alcohol consumption.

AUDIT "Clinical" Questions and Procedure

Trauma history

1. Have you injured your head since your 18th birthday?

(3) Yes (0) No

2. Have you broken any bones since your 18th birthday?

(3) Yes (0) No

Clinical examination

1. Conjunctival injections

(0) NOT PRESENT (1) MILD (2) MODERATE (3) SEVERE

2. Abnormal skin vascularization

(0) NOT PRESENT (1) MILD (2) MODERATE (3) SEVERE

3. Hand tremor

(0) NOT PRESENT (1) MILD (2) MODERATE (3) SEVERE

4. Tongue tremor

(0) NOT PRESENT (1) MILD (2) MODERATE (3) SEVERE

5. Hepatomegaly

(0) NOT PRESENT (1) MILD (2) MODERATE (3) SEVERE

GGT Values¹ Lower normal (0–30 IU/l) = (0)

Upper normal (30–50 IU/l) = (1)

Abnormal (50 IU/l) = (3)

¹These values may change with laboratory methods, and standards may vary with sex and age of the drinker.

Record sum of individual item scores here. _____

Scoring and Interpretation of AUDIT

As indicated by the AUDIT questions, each item is scored by checking the response category that comes closest to the patient's answer.

On the basis of evidence from the validation study (Saunders et al., in press), two cutoff points are suggested, depending on the purpose of the screening program or the nature of the research project. A score of 8 or more produces the highest sensitivity, while a score of 10 or more results in higher specificity. In general, high scores on the first three items in the absence of elevated scores on the remaining items suggest *hazardous* alcohol use. Elevated scores on items 4 through 6 imply the presence or emergence of *alcohol dependence*. High scores on the remaining items suggest *harmful* alcohol use. As discussed in the following section on diagnosis, each of these areas of alcohol-related problems implies different types of management.

The Clinical Screening Instrument is considered to be elevated when the total score is 5 or greater. Here, too, the examiner should give careful consideration to the different meanings attributed to alcohol-related trauma, physical signs, and the elevated liver enzyme. It should be noted that false positives can occur when the individual is accident prone, uses drugs (such as barbiturates) that induce GGT, or has hand tremor because of nervousness, neurological disorder, or nicotine dependence.

References

- Saunders, J.B., and Aasland, O.G. WHO Collaborative Project on the Identification and Treatment of Persons with Harmful Alcohol Consumption. Report on Phase I: Development of a Screening Instrument. Geneva, Switzerland: World Health Organization, 1987.
- Saunders, J.B.; Aasland, O.G.; Babor, T.F.; de la Fuente, J.R.; and Grant, M. WHO collaborative project on early detection of persons with harmful alcohol consumption. II. Development of the screening instrument "AUDIT." *British Journal of Addictions*, in press.

Index of Activities of Daily Living (ADLs)

The Index of Independence in Activities of Daily Living is based on an evaluation of the functional independence or dependence of patients in bathing, dressing, going to the toilet, transferring, continence, and feeding. Specific definitions of functional independence and dependence appear below the index. (These definitions can be used to convert the data recorded in the evaluation form in the next section into an Index of ADL grade.)

A—Independent in feeding, continence, transferring, going to the toilet, dressing, and bathing.

B—Independent in all but one of these functions.

C—Independent in all but bathing and one additional function.

D—Independent in all but bathing, dressing, and one additional function.

E—Independent in all but bathing, dressing, going to the toilet, and one additional function.

F—Independent in all but bathing, dressing, going to toilet, transferring, and one additional function.

G—Dependent in all six functions.

Other—Dependent in at least two functions, but not classifiable as C, D, E, or F.

Independence means without supervision, direction, or active personal assistance, except as specifically noted below. This is based on actual status and not on ability. A patient who refuses to perform a function is considered as not performing the function, even though he is deemed able.

Bathing (Sponge, Shower, or Tub)

Independent: assistance only in bathing a single part (as back or disabled extremity) or bathes self completely

Dependent: assistance in bathing more than one part of body; assistance in getting in or out of tub or does not bathe self

Dressing

Independent: gets clothes from closets and drawers; puts on clothes, outer garments, braces; manages fasteners; act of tying shoes is excluded

Dependent: does not dress self or remains partly undressed

Going to Toilet

Independent: gets to toilet; gets on and off toilet; arranges clothes; cleans organs of excretion; (may manage own bedpan used at night only and may or may not be using mechanical supports)

Dependent: uses bedpan or commode or receives assistance in getting to and using toilet

Transfer

Independent: moves in and out of bed independently and moves in and out of chair independently (may or may not be using mechanical supports)

Dependent: assistance in moving in or out of bed and/or chair; does not perform one or more transfers

Continence

Independent: urination and defecation entirely self-controlled

Dependent: partial or total incontinence in urination or defecation, partial or total control by enemas, catheters, or regulated use of urinals and/or bedpans

Feeding

Independent: gets food from plate or its equivalent into mouth; (precutting of meat and preparation of food, as buttering bread, are excluded from evaluation)

Dependent: assistance in act of feeding (see above); does not eat at all or parenteral feeding

Evaluation Form

Name _____ Day of Evaluation _____

For each area of functioning listed below, check description that applies. (The word "assistance" means supervision, direction, or personal assistance.)

Bathing—either sponge bath, tub bath, or shower.

- | | | |
|--|--|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Receives no assistance (gets in and out of tub by self if tub is usual means of bathing) | Receives assistance in bathing only one part of the body (such as back or a leg) | Receives assistance in bathing more than one part of the body (or not bathed) |

Dressing—gets clothes from closets and drawers—including underclothes, outer garments, and using fasteners (including braces if worn)

- | | | |
|---|---|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Gets clothes and gets completely dressed without assistance | Gets clothes and gets dressed without assistance except for assistance in tying shoes | Receives assistance in getting clothes or in getting dressed, or stays partially or completely undressed |

Toileting—going to the "toilet room" for bowel and urine elimination, cleaning self after elimination, and arranging clothes

- | | | |
|---|--|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Goes to "toilet room," cleans self, and arranges clothes without assistance (may use object for support such as cane, walker, or wheelchair and may manage night bedpan or commode, emptying same in morning) | Receives assistance in going to "toilet room," or in cleansing self or in arranging clothes after elimination or in use of night bedpan or commode | Doesn't go to room termed "toilet" for the elimination process |

Transfer—

- | | | |
|--|--|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Moves in and out of bed as well as in and out of chair without assistance (may be using object for support such as cane or walker) | Moves in and out of bed or chair with assistance | Doesn't get out of bed |

Continence—

| | | |
|--|----------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Controls urination and bowel movement completely by self | Has occasional "accidents" | Supervision helps keep urine or bowel control; catheter is used, or is incontinent |

Feeding—

| | | |
|-------------------------------|---|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Feeds self without assistance | Feeds self except for getting assistance in cutting meat or buttering bread | Receives assistance in feeding or is fed partly or completely by using tubes or intravenous fluids |

After filling out the form, convert the data collected into an ADL grade by using the definitions provided in the introductory section.

Source: Katz, S.; Ford, A.B.; Moskowitz, R.W.; Jackson, B.A.; and Jaffe, M.W. Studies of Illness in the Aged. The Index of ADL: A standardized measure of biological and psychosocial function. *Journal of the American Medical Association* 185:914-919, 1963.

References

Katz, S.; Downs, T.D.; Cash, H.R.; and Grotz, R.C. Progress in development of the Index of ADL. *Gerontologist* 10(1):20-30, 1970.

Katz, S., and Akpom, C.A. Index of ADL. *Medical Care* 14(suppl. 5):116-118, 1976.

Instrumental Activities of Daily Living (IADL) Scale

Self-Rated Version Extracted From the Multilevel Assessment Instrument (MAI)

1. Can you use the telephone:

| | |
|---|---|
| Without help, | 3 |
| With some help, or | 2 |
| Are you completely unable to use the telephone? | 1 |

2. Can you get to places out of walking distance:

| | |
|---|---|
| Without help, | 3 |
| With some help, or | 2 |
| Are you completely unable to travel unless special arrangements are made? | 1 |

3. Can you go shopping for groceries:

| | |
|---|---|
| Without help, | 3 |
| With some help, or | 2 |
| Are you completely unable to do any shopping? | 1 |

4. Can you prepare your own meals:

| | |
|---|---|
| Without help, | 3 |
| With some help, or | 2 |
| Are you completely unable to prepare any meals? | 1 |

5. Can you do your own housework:

| | |
|--|---|
| Without help, | 3 |
| With some help, or | 2 |
| Are you completely unable to do any housework? | 1 |

6. Can you do your own handyman work:

| | |
|--|---|
| Without help, | 3 |
| With some help, or | 2 |
| Are you completely unable to do any handyman work? | 1 |

7. Can you do your own laundry:

| | |
|---|---|
| Without help, | 3 |
| With some help, or | 2 |
| Are you completely unable to do any laundry at all? | 1 |

- 8a. Do you take any medications or use any medications?

| | |
|-----------------|---|
| (ASK Q. 8b) Yes | 1 |
| (ASK Q. 8c) No | 2 |

8b. (ASK IF SUBJECT TAKES MEDICINE NOW)

Do you take your own medicine:

(CHECK BELOW)

8c. (ASK IF SUBJECT DOES NOT TAKE MEDICINE NOW)

If you had to take medicine, can you do it:

(CHECK BELOW)

Without help (in the right doses at the right time),

3

With some help (take medicine if someone prepares it for you

2

and/or reminds you to take it), or

(Are you/would you be) completely unable to take your own medicines?

1

9. Can you manage your own money:

Without help,

3

With some help, or

2

Are you completely unable to handle money?

1

Note on Scoring: If fewer than 5 items are valid, then scoring cannot be done reliably.

Source: Lawton, M.P.; Moss, M.; Fulcomer, M.; and Kleban, M.H. A research and service-oriented Multilevel Assessment Instrument. *Journal of Gerontology* 37:91-99, 1982.

References

Lawton, M.P. Scales to measure competence in everyday activities. *Psychopharmacology Bulletin* 24(4):609-614, 1988.

Lawton, M.P., and Brody, E.M. Assessment of older people: Self-maintaining and instrumental activities of daily living. *Gerontologist* 9:179-186, 1969.

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Geriatric Depression Scale (GDS) Short Form

Choose the best answer for how you have felt over the past week:

- | | |
|---|--------|
| 1. Are you basically satisfied with your life? | YES/NO |
| 2. Have you dropped many of your activities and interests? | YES/NO |
| 3. Do you feel that your life is empty? | YES/NO |
| 4. Do you often get bored? | YES/NO |
| 5. Are you in good spirits most of the time? | YES/NO |
| 6. Are you afraid that something bad is going to happen to you? | YES/NO |
| 7. Do you feel happy most of the time? | YES/NO |
| 8. Do you often feel helpless? | YES/NO |
| 9. Do you prefer to stay at home, rather than going out and doing new things? | YES/NO |
| 10. Do you feel you have more problems with memory than most? | YES/NO |
| 11. Do you think it is wonderful to be alive now? | YES/NO |
| 12. Do you feel pretty worthless the way you are now? | YES/NO |
| 13. Do you feel full of energy? | YES/NO |
| 14. Do you feel that your situation is hopeless? | YES/NO |
| 15. Do you think that most people are better off than you are? | YES/NO |

Answers in bold indicate depression, and each answer counts as one point. For clinical purposes, a score greater than 5 suggests depression and warrants a followup interview. Scores greater than 10 are almost always depression.

Source: Sheikh, J.I., and Yesavage, J.A. Geriatric Depression Scale (GDS): Recent evidence and development of a shorter version. *Clinical Gerontologist* 5(1&2):165-173, 1986.

References

Brink, T.L.; Yesavage, J.A.; Lum, O.; Heersema, P.; Adey, M.B.; and Rose, T.L. Screening tests for geriatric depression. *Clinical Gerontologist* 1:37-44, 1982.

Yesavage, J.A.; Brink, T.L.; Rose, T.L.; Lum, O.; Huang, V.; Adey, M.B.; and Leirer, V.O. Development and validation of a geriatric depression screening scale: A preliminary report. *Journal of Psychiatric Research* 17:37-49, 1983.

The Center for Epidemiologic Studies Depression Scale (CES-D)

For the 20 items below, circle the number next to each item that best reflects how frequently the indicated event was experienced in the past 7 days.

| | <i>Rarely or none of the time (Less than 1 Day)</i> | <i>Some or a little of the time (1-2 Days)</i> | <i>Occasionally or a moderate amount of time (3-4 Days)</i> | <i>Most or all of the time (5-7 Days)</i> |
|--|---|--|---|---|
| DURING THE PAST WEEK: | | | | |
| 1. I was bothered by things that usually don't bother me. | 0 | 1 | 2 | 3 |
| 2. I did not not feel like eating: my appetite was poor. | 0 | 1 | 2 | 3 |
| 3. I felt that I could not shake off the blues even with help from my family or friends. | 0 | 1 | 2 | 3 |
| 4. I felt that I was just as good as other people. | 0 | 1 | 2 | 3 |
| 5. I had trouble keeping my mind on what I was doing. | 0 | 1 | 2 | 3 |
| 6. I felt depressed. | 0 | 1 | 2 | 3 |
| 7. I felt that everything I did was an effort. | 0 | 1 | 2 | 3 |
| 8. I felt hopeful about the future. | 0 | 1 | 2 | 3 |
| 9. I thought my life had been a failure. | 0 | 1 | 2 | 3 |
| 10. I felt fearful. | 0 | 1 | 2 | 3 |
| 11. My sleep was restless. | 0 | 1 | 2 | 3 |
| 12. I was happy. | 0 | 1 | 2 | 3 |
| 13. I talked less than usual. | 0 | 1 | 2 | 3 |
| 14. I felt lonely. | 0 | 1 | 2 | 3 |
| 15. People were unfriendly. | 0 | 1 | 2 | 3 |
| 16. I enjoyed life. | 0 | 1 | 2 | 3 |
| 17. I had crying spells. | 0 | 1 | 2 | 3 |
| 18. I felt sad. | 0 | 1 | 2 | 3 |

The Center for Epidemiologic Studies Depression Scale (CES-D) *Continued*

| | <i>Rarely or none of the time (Less than 1 Day)</i> | <i>Some or a little of the time (1–2 Days)</i> | <i>Occasionally or a moderate amount of time (3–4 Days)</i> | <i>Most or all of the time (5–7 Days)</i> |
|-------------------------------------|---|--|---|---|
| 19. I felt that people disliked me. | 0 | 1 | 2 | 3 |
| 20. I could not get “going.” | 0 | 1 | 2 | 3 |

Scoring: Since items 4, 8, 12, and 16 reflect positive experiences rather than negative ones, the scale should be reversed on these items so that 0 = 3, 1 = 2, 2 = 1, and 3 = 0. To determine the “depression score,” add together the number for each answer. The score will be somewhere in the range of 0 to 60. A score of 16 or greater indicates that some depression may have been experienced in the past week.

Source: Radloff, L.S. The CES-D Scale: A self-report depression scale for research in the general population. *Applied Psychological Measurement* 1(3):385–401, 1977.

Health Screening Survey (HSS), Revised

Check the appropriate answer

1. In the last three months, have you been dieting to lose weight?

☐ YES ☐ NO

IF YES: How many pounds have you managed to lose?

☐ 0 ☐ 1-3 ☐ 4-7 ☐ 8 or more

2. In the last three months, have you performed physical activity or exercise in your leisure time at least 20 minutes without stopping, enough to make you breathe hard and/or sweat?

☐ YES ☐ NO

IF YES: On average, how many days per week have you been exercising?

☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ Every day

3. In the last three months, have you been smoking cigarettes at all?

☐ YES ☐ NO

IF YES: On average, how many cigarettes have you been smoking each day?

☐ 1-9 ☐ 10-19 ☐ 20-29 ☐ 30 or more

4. In the last three months, have you been drinking alcoholic drinks at all (e.g., beer, wine, sherry, vermouth, or hard liquor)?

☐ YES ☐ NO

IF NO, go to question 5.

IF YES, ANSWER 4a through 4c.

- 4a. On average, how many days per week have you been drinking beer or wine coolers?

☐ None ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ Every day

On a day when you have had wine, sherry, or vermouth to drink, how many glasses, bottles, or cans have you been drinking?

☐ 1-2 ☐ 3-4 ☐ 5-8 ☐ 9-14 ☐ 15 or more

AND

- 4b. On average how many days per week have you been drinking wine, sherry, or vermouth?

☐ None ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ Every day

On a day when you have had wine, sherry, or vermouth to drink, how many glasses have you been drinking?

☐ 1-2 ☐ 3-4 ☐ 5-8 ☐ 9-14 ☐ 15 or more

AND

Health Screening Survey (HSS), Revised

Continued

- 4c. On average how many **days per week** have you been drinking **liquor** (gin, vodka, rum, brandy, whiskey, etc.)?

___ None ___ 1-2 ___ 3-4 ___ 5-6 ___ Every day

On a day when you have had liquor to drink, **how many single shots** have you been drinking?

___ 1-2 ___ 3-4 ___ 5-8 ___ 9-14 ___ 15 or more

5. In the last three months have you felt you should:

| | | | | |
|------------------------------|--------|---------------|-----------------|----------------|
| a. lose some weight | ___ No | ___ Sometimes | ___ Quite Often | ___ Very Often |
| b. cut down or stop smoking | ___ No | ___ Sometimes | ___ Quite Often | ___ Very Often |
| c. cut down or stop drinking | ___ No | ___ Sometimes | ___ Quite Often | ___ Very Often |
| d. do more to keep fit | ___ No | ___ Sometimes | ___ Quite Often | ___ Very Often |

6. In the last three months has anyone annoyed you or got on your nerves by telling you to:

| | | | | |
|------------------------------|--------|---------------|-----------------|----------------|
| a. change your weight | ___ No | ___ Sometimes | ___ Quite Often | ___ Very Often |
| b. cut down or stop smoking | ___ No | ___ Sometimes | ___ Quite Often | ___ Very Often |
| c. cut down or stop drinking | ___ No | ___ Sometimes | ___ Quite Often | ___ Very Often |
| d. do more to keep fit | ___ No | ___ Sometimes | ___ Quite Often | ___ Very Often |

7. In the last three months, have you felt guilty or bad about:

| | | | | |
|-----------------------|--------|---------------|-----------------|----------------|
| a. your weight | ___ No | ___ Sometimes | ___ Quite Often | ___ Very Often |
| b. how much you smoke | ___ No | ___ Sometimes | ___ Quite Often | ___ Very Often |
| c. how much you drink | ___ No | ___ Sometimes | ___ Quite Often | ___ Very Often |
| d. how unfit you are | ___ No | ___ Sometimes | ___ Quite Often | ___ Very Often |

8. In the last three months, have you been waking up wanting to:

| | | | | |
|----------------------------|--------|---------------|-----------------|----------------|
| a. exercise to keep fit | ___ No | ___ Sometimes | ___ Quite Often | ___ Very Often |
| b. smoke a cigarette | ___ No | ___ Sometimes | ___ Quite Often | ___ Very Often |
| c. have an alcoholic drink | ___ No | ___ Sometimes | ___ Quite Often | ___ Very Often |
| d. have something to eat | ___ No | ___ Sometimes | ___ Quite Often | ___ Very Often |

9. Now that you have completed this form, do you think you **currently** have:

| | | | | |
|-----------------------|----------------|--------------|--------|----------------|
| a. a weight problem | ___ Definitely | ___ Probably | ___ No | ___ Don't Know |
| b. a smoking problem | ___ Definitely | ___ Probably | ___ No | ___ Don't Know |
| c. a drinking problem | ___ Definitely | ___ Probably | ___ No | ___ Don't Know |
| d. a fitness problem | ___ Definitely | ___ Probably | ___ No | ___ Don't Know |

10. Thinking back, would you say at any time in the **past** you had:

| | | | | |
|-----------------------|----------------|--------------|--------|----------------|
| a. a weight problem | ___ Definitely | ___ Probably | ___ No | ___ Don't Know |
| b. a smoking problem | ___ Definitely | ___ Probably | ___ No | ___ Don't Know |
| c. a drinking problem | ___ Definitely | ___ Probably | ___ No | ___ Don't Know |
| d. a fitness problem | ___ Definitely | ___ Probably | ___ No | ___ Don't Know |

Health Screening Survey (HSS), Revised

Continued

Scoring: The HSS contains four subscales: one measuring amount of alcohol consumption (question 4 a, b, c; Kristenson and Trell, 1982), the CAGE questionnaire (questions 5–8; Mayfield et al., 1974), one for self-perception of current problem with alcohol (question 9), and one for self-perception of past problem with alcohol (question 10). Consumption of 20 or more drinks per week, two or more positive responses to the four CAGE questions, self-perception of a current problem with alcohol use, *or* self-perception of a past problem with alcohol use indicates problem drinking.

Source: Fleming, M.F., and Barry, K.L. A three-sample test of a masked alcohol screening questionnaire. *Alcohol and Alcoholism* 26(1):81–91, 1991.

References

- Kristenson, H., and Trell, E. Indicators of alcohol consumption: Comparisons between a questionnaire (Mm-MAST), interviews, and serum γ -glutamyl transferase (GGT) in a health survey of middle-aged males. *British Journal of Addiction* 77:297–304, 1982.
- Mayfield, D.; McLeod, G.; and Hall, P. The CAGE questionnaire: Validation of a new alcoholism screening instrument. *American Journal of Psychiatry* 131:1121–1128, 1974.

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Appendix B

References

- Adams, W.L.; Barry, K.L.; and Fleming, M.F. Screening for problem drinking in older primary care patients. *Journal of the American Medical Association* 276(24):1964-1967, 1996.
- Adams, W.L.; Yaun, Z.; Barboriak, J.J.; and Rimm, A.A. Alcohol-related hospitalizations of elderly people: Prevalence and geographic location in the United States. *Journal of the American Medical Association* 270(10):1222-1225, 1993.
- American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed. Washington, DC: American Psychiatric Association, 1994.
- American Society of Addiction Medicine. *Patient Placement Criteria for the Treatment of Substance-Related Disorders*, 2nd ed. Washington, DC: American Society of Addiction Medicine, 1996.
- Atkinson, R.M. Aging and alcohol use disorders: Diagnostic issues in the elderly. *International Psychogeriatrics* 2:55-72, 1990.
- Atkinson, R.M. Treatment programs for aging alcoholics. In: Beresford, T., and Gomberg, E., eds. *Alcohol and Aging*. New York: Oxford University Press, 1995. pp. 186-210.
- Atkinson, R.M., and Ganzini, L. Substance abuse. In: Coffey, C.E., and Cummings, J.L., eds. *Textbook of Geriatric Neuropsychiatry*. Washington, DC: American Psychiatric Press, 1994. pp. 297-321.
- Babor, T.F.; de la Fuente, J.R.; Saunders, J.; and Grant, M. AUDIT: *The Alcohol Use Disorders Identification Test: Guidelines for Its Use in Primary Health Care*. Geneva, Switzerland: World Health Organization, 1992.
- Beresford, T.P.; Blow, F.C.; Brower, K.J.; Adams, K.M.; and Hall, R.C.W. Alcoholism and aging in the general hospital. *Psychosomatics* 29:61-72, 1988.
- Blow, F.C.; Brower, K.J.; Schulenberg, J.E.; Demodananberg, L.M.; Young, J.P.; and Beresford, T.P. The Michigan Alcoholism Screening Test—Geriatric Version (MAST-G): A new elderly-specific screening instrument. *Alcoholism: Clinical and Experimental Research* 16:372, 1992.
- Booth, B.M.; Blow, F.C.; Cook, C.A.; Bunn, J.Y.; and Fortney, J.C. Age and ethnicity among hospitalized alcoholics: A nationwide study. *Alcoholism: Clinical and Experimental Research* 16:1029-1034, 1992.
- Brower, K.J.; Mudd, S.; Blow, F.C.; Young, J.P.; and Hill, E.M. Severity and treatment of alcohol withdrawal in elderly versus younger patients. *Alcoholism: Clinical and Experimental Research* 18(1):196-201, 1994.
- Bucholz, K.K.; Sheline Y.; and Helzer, J.E. The epidemiology of alcohol use, problems, and dependence in elders: A review. In: Beresford, T.P. and Gomberg, E., eds. *Alcohol and Aging*. New York: Oxford University Press, 1995. pp. 19-41.
- Butler, R.N. Age-ism: Another form of bigotry. *Gerontologist* 9:243-246, 1969.
- Center for Substance Abuse Treatment. *Bringing Excellence to Substance Abuse Services in Rural and Frontier America*. Technical Assistance Publication (TAP) Series, Number 20. DHHS Pub. No. (SMA) 97-3134. Washington, DC: U.S. Government Printing Office, 1997.

- Center for Substance Abuse Treatment. *Rural Issues in Alcohol and Other Drug Abuse Treatment*. Technical Assistance Publication (TAP) Series, Number 10. DHHS Pub. No. (SMA) 96-3099. Washington, DC: U.S. Government Printing Office, 1996.
- Center for Substance Abuse Treatment. *Treating Alcohol and Other Drug Abusers in Rural and Frontier Areas*. Technical Assistance Publication (TAP) Series, Number 17. DHHS Pub. No. (SMA) 95-3054. Washington, DC: U.S. Government Printing Office, 1995.
- Cooperstock, R., and Parnell, P. Research on psychotropic drug use: A review of findings and methods. *Social Science and Medicine* 16:1179-1196, 1982.
- Cotton, N.S. The familial incidence of alcoholism: A review. *Journal of Studies of Alcohol* 40:89-116, 1979.
- D'Archangelo, E. Substance abuse in later life. *Canadian Family Physician* 39:1986-1993, 1993.
- DeHart, S.S., and Hoffman, H.G. Screening and diagnosis of "alcohol abuse and dependence" in older adults. *International Journal of the Addictions* 30:1717-1747, 1995.
- DiClemente, C.C.; Prochaska, J.O.; Fairhurst S.K.; Velicer, W.F.; Velasquez, M.M.; and Rossi, J.S. The process of smoking cessation: An analysis of precontemplation, contemplation, and preparation stages of change. *Journal of Consulting and Clinical Psychology* 59(2):295-304, 1991.
- Douglass, R.L. Aging and alcohol problems: Opportunities for socioepidemiologic research. In: Galanter, M., ed. *Recent Developments in Alcoholism*. New York: Plenum Press, 1984. pp. 251-266.
- Dufour, M.C.; Archer, L.; and Gordis, E. Alcohol and the elderly. *Clinics in Geriatric Medicine* 8:127-141, 1992.
- Ewing, J.A. Detecting alcoholism: The CAGE Questionnaire. *Journal of the American Medical Association* 252:1905-1907, 1984.
- Finlayson, R.; Hurt, R.; Davis, L.; and Morse, R. Alcoholism in elderly persons: A study of the psychiatric and psychosocial features of 216 inpatients. *Mayo Clinic Proceedings* 63:761-768, 1988.
- Finlayson, R.E. Misuse of prescription drugs. *International Journal of the Addictions* 30(13&14):1871-1901, 1995.
- Fleming, A.S.; Buchanan, J.G., Santos, J.F.; and Rickards, L.D. *Mental Health Services for the Elderly: Report on a Survey of Community Mental Health Centers*, Vol. I. Washington, DC: The Action Committee to Implement the Mental Health Recommendations of the 1981 White House Conference on Aging, 1984.
- Fleming, M., and Barry, K. A three-sample test of a masked alcohol screening questionnaire. *Alcohol and Alcoholism* 26:81-91, 1991.
- Fleming, M.; Barry, K.L.; Adams, W.; Manwell, L.B.; and Kreckler, M. Guiding Older Adult Lifestyles (Project GOAL): The effectiveness of brief physician advice for alcohol problems in older adults. Manuscript submitted for publication, 1997a.
- Fleming, M.F.; Barry, K.L.; Manwell, L.B.; Johnson, K.; and London, R. Brief physician advice for problem alcohol drinkers: A randomized controlled trial in community-based primary care practices. *Journal of the American Medical Association* 277:1039-1045, 1997b.
- Fortney, J.C.; Booth, B.M.; Blow, F.C.; and Bunn, J.Y. The effects of travel barriers and age on the utilization of alcoholism treatment aftercare. *American Journal of Drug and Alcohol Abuse* 21(3):391-406, 1995.
- Gomberg, E.S.L. "Elderly alcoholic men and women in treatment." Paper presented at the Research Society on Alcoholism Annual Scientific Meeting, San Diego, California, 1992a.
- Gomberg, E.S.L. Medication problems and drug abuse. In: Turner, F.J., ed. *Mental Health and the Elderly*. New York: Free Press, 1992b. pp. 355-374.

- Hodgson, R., and Rollnick, S. How brief intervention works: Representative cases as viewed by the health advisors. In: Babor, T.F., and Grant, M., eds. *Project on Identification and Management of Alcohol-Related Problems: Report on Phase II. A Randomized Clinical Trial of Brief Interventions in Primary Health Care*. Geneva, Switzerland: World Health Organization, 1992. pp. 221-232.
- Institute of Medicine. *Broadening the Base of Treatment for Alcohol Problems*. Washington, DC: National Academy Press, 1990.
- Johnson, V.E. *I'll Quit Tomorrow*. New York: Harper and Row, 1973.
- Koenig, H.G., and Blazer, D.G., II. Depression. In: Birren, J.E., ed. *Encyclopedia of Gerontology: Age, Aging, and the Aged*. Vol. I. San Diego, CA: Academic Press, 1996. pp. 415-428.
- Kofoed, L.L.; Tolson, R.L.; Atkinson, R.M.; Toth, R.L.; and Turner, J.A. Treatment compliance of older alcoholics: An elder-specific approach is superior to "mainstreaming." *Journal of Studies on Alcohol* 48:47-51, 1987.
- Lebowitz, B.D. Correlates of success in community mental health programs for the elderly. *Hospital and Community Psychiatry* 39:721-722, 1988.
- Lebowitz, B.D.; Light, E.; and Bailey, F. Mental health center services for the elderly: The impact of coordination with area agencies on aging. *Gerontologist* 27(6):699-702, 1987.
- Lehman, A.F. A quality of life interview for the chronically mentally ill. *Evaluation and Program Planning* 11:51-62, 1988.
- Liberto, J.G.; Oslin, D.W.; and Ruskin, P.E. Alcoholism in older persons: A review of the literature. *Hospital and Community Psychiatry* 43(10):975-984, 1992.
- Light, E.; Lebowitz, B.D.; and Bailey, F. CMHC's and elderly services: An analysis of direct and indirect services. *Community Mental Health Journal* 22(4):294-302, 1986.
- Liskow, B.I.; Rinck, C.; Campbell, J.; and DeSousa, C. Alcohol withdrawal in the elderly. *Journal of Studies on Alcohol* 50:414-421, 1989.
- McHorney, C.A.; Ware, J.E.; Lu, J.F.R.; and Sherbourne, C.D. The MOS 36-Item Short-Form Health Survey (SF-36): III. Tests of data quality, scaling assumptions, and reliability across diverse patient groups. *Medical Care* 32:40-66, 1994.
- McLellan, A.T., and Durell, J. Outcome evaluation in psychiatric and substance abuse treatments: Concepts, rationale, and methods. In: Sederer, L., and Dickey, B., eds. *Outcomes Assessment in Clinical Practice*. Baltimore, MD: Williams & Wilkins, 1996. pp. 34-44.
- McLellan, A.T.; Luborsky, L.; Cacciola, J.; and Griffith, J. New data from the addiction severity index: Reliability and validity in three centers. *Journal of Nervous Disease* 173:412-423, 1985.
- McLellan, A.T.; Luborsky, L.; O'Brien, C.P.; and Woody, G.E. An improved diagnostic instrument for substance abuse patients: The addiction severity index. *Journal of Nervous and Mental Disorders* 168:26-33, 1990.
- Miller, W.R., and Hester, R.K. Inpatient alcoholism treatment: Who benefits? *American Psychologist* 41:794-805, 1986.
- Miller, W.R., and Munoz, R.F. *How To Control Your Drinking*. Englewood Cliffs, NJ: Prentice-Hall, 1976.
- Miller, W.R., and Rollnick, S. *Motivational Interviewing*. New York: Guilford Press, 1991.
- Miller, W.R., and Sanchez, V.C. Motivating young adults for treatment and lifestyle change. In: Howard, G.S., and Nathan, P.E. *Alcohol Use and Misuse by Young Adults*. South Bend, IN: University of Notre Dame Press, 1994.
- Miller, W.R., and Taylor, C.A. Relative effectiveness of bibliotherapy, individual and group self-control training in the treatment of problem drinkers. *Addictive Behaviors* 5:13-24, 1980.
- Myers, J.K.; Weissman, M.M.; Tischler, G.L.; Holzer, C.E., III; Leaf, P.J.; Orvaschel, H.; Anthony, J.C.; Boyd, J.H.; Burke, J.D., Jr.; Kramer, M.; and Stolzman, R. Six-month prevalence of psychiatric disorders in three communities: 1980-1982. *Archives of General Psychiatry* 41:959, 1984.

- National Institute on Alcohol Abuse and Alcoholism. *The Physicians' Guide to Helping Patients With Alcohol Problems*. NIH Pub. No. 95-3769. Rockville, MD: National Institute on Alcohol Abuse and Alcoholism, 1995.
- Oslin, D.; Liberto, J.G.; O'Brien, J.; Krois, S.; and Norbeck, J. Naltrexone as an adjunctive treatment for older patients with alcohol dependence. *American Journal of Geriatric Psychiatry* 5:324-332, 1997.
- Pomara, N.; Stanley, B.; Block R.; Berchou, R.C.; Stanley, M.; Greenblatt, D.J.; Newton, R.E.; and Gershon, S. Increased sensitivity of the elderly to the central depressant effects of diazepam. *Journal of Clinical Psychiatry* 46:185-187, 1985.
- Prochaska, J.O., and DiClemente, C.C. Processes and stages of change in smoking, weight control, and psychological distress. In: Schiffman, S., and Wills, T., eds. *Coping and Substance Abuse*. New York: Academic Press, 1985, pp. 319-245.
- Prochaska, J., and DiClemente, C. Toward a comprehensive model of change. In: Miller, W.R., and Heather, N., eds. *Treating Addictive Behaviors: Processes of Change*. New York: Plenum Press, 1986, pp. 3-27.
- Rascko, R. "Gatekeepers" do the casefinding in Spokane. *Aging* 361:38-40, 1990.
- Robins, L.N.; Helzer, J.E.; Croughan, J.; and Ratcliffe, K.S. National Institute of Mental Health Diagnostic Interview Schedule: Its history, characteristics, and validity. *Archives of General Psychiatry* 38:381-389, 1981.
- Roy, W., and Griffin, M. Prescribed medications and the risk of falling. *Topics in Geriatric Rehabilitation* 5(20):12-20, 1990.
- Saunders, P.A. Epidemiology of alcohol problems and drinking patterns. In: John, R.M.; Copeland, M.T.; Aboou-Saleh, M.T.; and Blazer, D.G., eds. *Principles and Practice of Geriatric Psychiatry*. New York: Wiley, 1994. pp. 801-805.
- Schonfeld, L., and Dupree, L.W. Treatment alternatives for older alcohol abusers. In: Gurnack, A., ed. *Older Adults' Misuse of Alcohol, Medicines, and Other Drugs: Research and Practice Issues*. New York: Springer, 1996. pp. 113-131.
- Sheahan, S.L.; Coons, S.J.; Robbins, C.A.; Martin, S.S.; Hendricks, J.; and Latimer, M. Psychoactive medication, alcohol use and falls among older adults. *Journal of Behavioral Medicine* 18(2):127-140, 1995.
- Sheahan, S.L.; Hendricks, J.; and Coons, S.J. Drug misuse among the elderly: A covert problem. *Health Values* 13(3):22-29, 1989.
- Smith, D.M., and Atkinson, R.M. Alcoholism and dementia. In: Gurnack A., ed. *Older Adults' Misuse of Alcohol, Medicines, and Other Drugs: Research and Practice Issues*. New York: Springer, 1997. pp. 132-158.
- Smith, V. Symptom checklist-90-revised (SCL-90-R) and the brief symptom inventory (BSI). In: Sederer, L., Dickey, B., eds. *Outcomes Assessment in Clinical Practice*. Baltimore: Williams & Wilkins, 1996.
- Sobell, L.C.; Brown, J.; Leo, G.I.; and Sobell, M.B. The reliability of the alcohol timeline followback when administered by telephone and by computer. *Drug and Alcohol Dependence* 42(1):49-54, 1996.
- Sobell, L.C.; Sobell, M.B.; Leo, G.I.; and Cancilla, A. Reliability of a timeline method: Assessing normal drinkers' reports of recent drinking and a comparative evaluation across several populations. *British Journal of Addiction* 83(4): 393-402, 1988.
- Spencer, G. *Projections of the Population of the United States, by Age, Sex, and Race: 1988 to 2080*. Series P-25, No. 1018. Washington, DC: U.S. Department of Commerce, 1989.
- Spitzer, R.L., and Williams, J.B. *Structured Clinical Interview for DSM-III (SCID)*. New York: Biometrics Research Division, New York State Psychiatric Institute, 1985.

- Stinson, F.S.; Dufour, M.C.; and Bertolucci, D. Alcohol-related morbidity in the aging population. *Alcohol Health and Research World* 13:80-87, 1989.
- Twerski, A.J. Early intervention in alcoholism: Confrontational techniques. *Hospital and Community Psychiatry* 34:1027-1030, 1983.
- U.S. Bureau of the Census. *65+ in the United States*. Current Population Reports, Special Studies, Number P23-190. Washington, DC: U.S. Government Printing Office, 1996.
- Velicer, W.F.; Prochaska, J.O.; Rossi, J.S.; and Snow, M.G. Assessing outcome in smoking cessation studies. *Psychological Bulletin* 111(1):23-41, 1992.
- Wallace, P., and Haines, A. Use of a questionnaire in general practice to increase the recognition of patients with excessive alcohol consumption. *British Medical Journal* 290:1949-1953, 1985.
- Woods, J.H., and Winger, G. Current benzodiazepine issues. *Psychopharmacology* 118:107-115, 1995.

Appendix C

TIP 26 Consensus Panel

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Concise Desk Reference Guides have been prepared for five published TIPS. These TIPS and their related guides are listed below:

- TIP 24 *A Guide to Substance Abuse Services for Primary Care Clinicians* BKD234**
Concise Desk Reference Guide MS631
Guia de Servicios para el Abuso de Sustancias Para Proveedores de Atencion Primaria de la Salud
MS631S
- TIP 25 *Substance Abuse Treatment and Domestic Violence* BKD239**
Linking Substance Abuse Treatment and Domestic Violence Services: A Guide for Treatment Providers MS668
Linking Substance Abuse Treatment and Domestic Violence Services: A Guide for Administrators
MS667
- TIP 26 *Substance Abuse Among Older Adults* BKD250**
Substance Abuse Among Older Adults: A Guide for Treatment Providers MS669
Substance Abuse Among Older Adults: A Guide for Social Service Providers MS670
Substance Abuse Among Older Adults: Physicians Guide MS671
- TIP 27 *Comprehensive Case Management for Substance Abuse Treatment* BKD251**
Case Management for Substance Abuse Treatment: A Guide for Administrators MS672
Case Management for Substance Abuse Treatment: A Guide for Treatment Providers MS673
- TIP 28 *Naltrexone and Alcoholism Treatment* BKD268**
Naltrexone and Alcoholism Treatment: Physicians Guide MS674

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